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BUFFERING EFFECTS OF JOB AND PERSONAL RESOURCES ON THE HEALTH AND WELL-BEING OF CARE WORKERS

A dissertation
by

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Abstract

The care industry is encountering a critical demand for care workers in the formal and informal sectors. As a result, the healthcare industry is strained from the increasing shortage of workers and capacity in facilities. Moreover, there is a desire among the aged to age in place, thus, care provided in the home and community is also on the rise. The requisite for care workers in the U.S. suggests that this population is vulnerable to job and personal demands in the workplace that are associated with negative health outcomes such as poor sleep and burnout. The purpose of this three-paper dissertation is to evaluate the moderating effects of job and personal resources on the health and well-being of nurses and patient care associates (PCAs) in the formal sector and Filipina care workers in the informal sector.

The first two papers used the Boston Hospital Health Workers Study, a longitudinal study that was established in 2006 to examine the working organization and condition, behaviors, and health outcomes among healthcare workers from two large hospitals in the same health system in Boston. The first paper (N=845) used a mixed methods approach and used logistic regression analysis to examine the association of discrimination and short sleep and interaction terms to assess the buffering effect of people-oriented culture between discrimination and short sleep. The

qualitative section used a combination of grounded theory and thematic analysis of interviews of unit nurse directors (N=16) to gain an in-depth understanding of how discrimination transpires in the workplace and the resources available to address discrimination and poor sleep among care workers. The second paper (N=874) evaluated the association of job and personal demands and burnout using logistic regression. Interaction terms were implemented to assess the buffering effect of workplace flexibility between job and personal demands and burnout. The third paper used semi-structured interviews of Filipina care workers in New England (N=14). A combination of grounded theory and thematic analysis were used to analyze the qualitative data.

In Paper 1, findings showed that people-oriented culture did not buffer the relationship of discrimination and short sleep. However, people-oriented culture slightly attenuated the association of discrimination and odds of short sleep. Qualitative findings illuminated that discrimination transpired among co-workers in relation to their job titles and while numerous job resources are available, these resources do not necessarily address discrimination and promotion of inclusivity. In the second paper, workplace flexibility moderated the relationship between married healthcare workers without children and odds of burnout. Moreover, there are significant associations between active (high demand, high control) and high strained (high demand, low control) workers with perceived low workplace flexibility and odds of burnout. In the third paper, qualitative findings highlighted that Filipina care workers are tasked with multiple job responsibilities that are associated with abuse and injuries and personal demands of providing financial care to their family and saving face from divulging difficult experiences. While job resources like job contracts are helpful in lowering the likelihood of abuse, lack of government oversight facilitated violence in the workplace. Filipina care workers found support through community organizations and advocating for themselves and other fellow care workers.

Findings from this study suggest that organizational policies and practices play a role in attenuating poor health outcomes among care workers but not all experience these policies and practices equally. Barriers such as not acknowledging discrimination directly and providing specific resources to discrimination, differing control in the workplace because of job title and racial and gender identities, and reporting abuse and violence in the workplace outweighing the cost of the demand to provide the needs for family members prevent care workers from being able to fully benefit from these policies and practices. Nevertheless, while structural changes take time, unit managers in formal settings and employers in informal settings can address these inequities in their specific settings to improve the health and well-being of care workers. This dissertation will assist the field of social work to advocate for federal, state-level, local, and organizational policies to be implemented in the workplace that will adjust to the needs of healthcare and domestic workers. Furthermore, the study can also inform future interventions to integrate effective organizational policies that reduce poor sleep quality and burnout among care workers.

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Chapter I. Introduction

The care industry is encountering a critical demand for care workers in the formal and informal sectors, with higher than average job growth compared to most occupations in the country (Bureau of Labor Statistics U.S. Department of Labor, n.d.-d, n.d.-c, n.d.-b, n.d.-a). Care workers are individuals who provide in-person services to care recipients that help develop their human capabilities pertaining to their health, skills, and activities of daily living (England et al., 2002). The types of care workers range from physicians and nurses to domestic workers, babysitters, nannies, and housecleaners. These workers work in formal and informal sectors. While the formal sector grants protections and rights to workers from the federal to organizational levels, workers in the informal sector have limited to non-existing rights (Indon, 2002; Vogel, 2006). Care work is largely gendered with womxn dominating 25 out of 30 health occupations, with higher percentages in the low-wage sectors (U.S. Department of Health and Human Services et al., 2017). The industry is also racially disproportionate, with white care workers comprising the majority of high-wage care work occupations whereas Black, Indigenous, and People of Color (BIPOC) encompass the low-wage care sector (Burnham & Theodore, 2012). Globalization is shifting the make-up of care work increasing the number of immigrant care workers in both sectors demonstrating that about one in six care workers in the formal sector (Patel et al., 2018) and 46% in the informal sector are non-U.S. born (Burnham & Theodore, 2012). An expeditious aging population and shortage of care workers (Cohn & Taylor, 2010) suggests that the care work population is vulnerable to abuse, violence, and injury in the workplace. The care workers that will be evaluated for this study are nurses and patient care associates (PCA) in the formal sector and those in the informal sector who are domestic workers, nannies, and Certified Nursing Assistants (CNA).

Care workers in the formal sector experience numerous types of demands and stressors. Most healthcare settings operate in 24/7 care and healthcare workers often work in long shifts, and some rotating shifts (Pilcher et al., 2000; Savic et al., 2019). Differences in job titles also engender varying demanding job responsibilities and disparities in wage gaps, low-wage healthcare workers may have to work in iterations of a second job or part-time work (Caruso, 2014). Other aspects of the workplace can contribute to the working experience of healthcare workers. Healthcare workers from underrepresented backgrounds, specifically, womxn, ethnic/racial minorities, lesbian, gay, bisexual, transgender, queer (LGBTQ+), and immigrants, also experience additional forms of abuse such as discrimination (Okechukwu et al., 2014). These forms of discrimination occur between co-workers, from patients, and their family members (Eliason et al., 2011; Squillace et al., 2009; R. M. Wheeler et al., 2014). Researchers suggest that these statistics are often underreported because of numerous reasons including vague definitions of what constitutes as violence, abuse, fear of retribution, and lack of management accountability (J. P. Phillips, 2016). In addition, they also experience biomechanical exposures such as bending and lifting of patients specifically among PCAs (Dennerlein et al., 2012).

Beyond the scope of the workplace, healthcare workers also experience personal demands. Healthcare workers reported feeling guilt for not being able to provide care to their family once they arrive home from work due to the demands of their job (Bullock & Waugh, 2004). Responsibilities in the workplace are also often relegated to womxn due to patriarchal gender roles (Blanch & Aluja, 2012). Variations in familial structures may also influence additional stressors especially among single parents who may not have additional support in providing care for their children (Richard & Lee, 2019).

The compounding demands of the job and personal spheres of care workers in the formal sector may be associated with poor health outcomes. Among the highest cases of injuries and illnesses are reported by healthcare workers (Occupational Safety and Health Administration, 2013). Common cases of injuries in the workplace are overexertion and bodily reaction, slips, trips, and falls, contact with objects, violence, and exposure to substances (Occupational Safety and Health Administration, 2013). Several studies have shown that job and personal demands are associated with musculoskeletal injury (Sabbath et al., 2014), depressive symptoms (Marchiondo et al., 2017), burnout (Livne & Goussinsky, 2018), and poor sleep quality (Hansen et al., 2014, 2018; Sorensen et al., 2011) among healthcare workers. These may lead to decreased work productivity (Berry et al., 2012) which may affect not only the health and well-being of healthcare workers but also the quality of care being provided to patients.

Care workers in the informal sector also experience job and personal demands. Care workers are exposed to toxic chemicals from cleaning supplies and musculoskeletal injuries from performing strenuous activities (Theodore et al., 2018). They are also exposed to sharp objects and other blood and bodily fluids from administering medical procedures at-home (Quinn et al., 2009). Violence and abuse from care recipients and their family members are common (Quinn et al., 2016). Some care workers who live with their employer provide 24/7 care like administering medicine in odd hours of the night which can interrupt their sleep (Burnham & Theodore, 2012). Akin to care workers in the formal sector, care workers also experience personal demands and engage in second shifts once they return home from work (Boris & Fish, 2014; Hochschild & Machung, 2012). Immigrant care workers who do not live with their family in the same country perform transnational mothering (Parreñas, 2001b) through the use of various mediums of

technology (Francisco-Menchavez, 2018a). These experiences have been associated with burnout, stress, and depression (Bagley et al., 1997; Hall et al., 2019).

With known outcomes of the job and personal demands among care workers in the formal and informal sectors, it is imperative to explore potential buffers between experiences of demands and negative health outcomes. In the formal sector, organizational policies and practices can serve as a moderator. For instance, practices in the workplace that builds a working environment that fosters friendliness, trust, cooperation, and support are associated in lowering likelihood of feeling ostracized, distressed, and emotional exhaustion (López Gómez et al., 2019; Nelson et al., 2014; Ruggs et al., 2015; Willemse et al., 2012). Workplace flexibility also provides workers more control in executing their job responsibilities which has been associated with less stress (Jeffrey Hill, Jacob, et al., 2008) and adaptation of preventative health behaviors (Sabbath, Sparer, et al., 2018). Within the context of care work in the informal sector in the U.S., currently, the country does not provide care workers federal policies that secure their protection and safety at work and instead, are left with limited state- or city-level policies in a few states under iterations of the Domestic Worker's Bill of Rights (Applebaum, 2010). Thus, organizational policies and practices in the informal sector vary. Organic practices such as fostering positive relationships with employers and familial and peer support through technology can function as personal resources for care workers (Francisco-Menchavez, 2018a; Timonen & Doyle, 2010).

The purpose of this three-paper dissertation is to assess the moderating effects of job and personal resources on the health and well-being of care workers. The overarching question of the present dissertation posits, what are the buffering effects of job and personal resources on the association of job and personal demands on the health and well-being of care workers? The

results of this study will assist the field of social work to advocate for federal, state-level, and organizational policies to be implemented in the workplace to improve the welfare of care workers in the formal and informal sectors.

Specific Aims

The research questions postulated will be explored and examined through the aims of the three papers:

Paper 1 aims to examine if people-oriented culture buffers the relationship of discrimination and short sleep among healthcare workers.

Paper 2 aims to examine if workplace flexibility moderates the relationship of job and personal demands and burnout among healthcare workers.

Paper 3 aims to explore the experiences of Filipina care workers in the informal sector and understand how they construct personal and job resources to alleviate negative working conditions.

Chapter II. Theoretical Underpinnings

Job Demands-Resources Model (JD-R model)

The JD-R model contends that extreme job demands and poor job resources leads to strain and over exhaustion overtime preceding adverse organizational and individual outcomes. However, the model argues that clusters of job resources that addresses various aspects of job demands can mitigate the stress caused by job demands and in turn can increase motivation and improve individual performance and well-being which can benefit the organization (Bakker & Demerouti, 2007; Demerouti et al., 2001). Job demands pertain to sustained physical, psychological, and organizational exertion overtime that has somatic, mental, and resource-related costs (Demerouti et al., 2001). Conversely, job resources are physical, psychological, social and organizational features that can help accomplish work tasks, reduce stressors related to job demands, and incite growth and development among workers. These resources can be situated in various levels of the organization from the broad level (e.g. opportunities for promotion, learning, decision-making and policies protecting the well-being and rights of workers, etc.) and the interpersonal or social level (e.g. supervisor and peer support, autonomy, feedback, etc.) (Bakker & Demerouti, 2007). Another premise of the JD-R model highlights the psychological processes involved in the materialization of job strain and motivation. High job demands and stressful working conditions can cause physical and mental depletion and fatigue among workers. Workers employ performance-protection strategies to respond to such exigencies. These include sympathetic activation or corporeal responses concerning the autonomic and endocrine retorts of the body to stressors and/or subjective effort or the effort and control to process information (Bakker & Demerouti, 2007). High job demands can cause elevated and sustained activation of these two components that leads to poor overall well-being

of the individual. On the other hand, the second psychological process argues that a function of job resources can engender motivation among workers which can lead to their engagement and commitment to the organization (Bakker & Demerouti, 2007). Another aspect to the consider about the JD-R model is the complex interaction of the individual and the amalgamation of the job demands and resources available in the organization can have differing outcomes based on the characteristics of the worker (e.g. job type, socioeconomic status, gender, etc.). Several studies used the JD-R model to examine the influence of job resources on the job demands of workers and found that effective job resources can abate burnout, depression, and intention to leave among various types of workers (Hakanen et al., 2008; Jourdain & Chênevert, 2010; Schaufeli, Bakker, et al., 2009)

Social Dominance Theory

Social Dominance Theory (SDT) posits that societies are arranged in group-based social hierarchies enforced through a system of institutions, ideologies, and interpersonal relationships (Sidanius et al., 2004; Sidanius & Pratto, 2012). It is consisted of three branches of systems: 1) a system that privileges adults and middle-age over younger people in relation to power, 2) patriarchal system that stretches social and political power to men over women, and 3) a subjective system that hierarchically places groups of dominance and subordinate based on social categories such as race, caste, religion, social class, etc. (Sidanius & Pratto, 2012). Those in the dominant group behave and tailor institutions that allocate and sustain power and resources in their group while those in the subordinate group are given unwanted matters and issues such as experiencing poverty, homelessness, etc. (Sidanius et al., 2004). However, the imbalance of power is challenged and sustained by opposing forces of hierarchy-enhancing and hierarchy-attenuating legitimizing ideologies and social institutions. The ideologies that people use and

subscribe to are identified as legitimizing myths which are stereotypes, values, representations that dictate and falsely validate behaviors and assumptions about groups of people (Sidanius & Pratto, 2012). Because of the limited access to resources and oppression experienced by the subordinate group, they behave in ways that fortify discriminating stereotypes described as behavioral asymmetry (Sidanius & Pratto, 2012). The ideologies and behaviors are then further reinforced by institutions such as the criminal justice system that unjustly and racially profiles people of color, specifically Black people. Hierarchy-attenuating ideologies and social institutions on the other hand, challenges and dismantles discriminating ideologies and institutions through transformative power reified in institutions such as civil rights organizations, charities, non-profit organizations, etc. (Sidanius & Pratto, 2012). SDT argues that the desire to maintain and sustain intergroup power within the dominant group interplay and are imbedded in various levels of institutions. Within the sphere of care work, subjective factors such as an individual's job title, race, gender, sexual orientation, social class, etc. can have varying outcomes in how organizational policies are enforced, their interactions with their co-workers and patients, and the type of jobs that are made available to them (Eliason et al., 2011; Hurtado et al., 2012; Probst et al., 2010; Sabbath, Sparer, et al., 2018).

Cultural Wealth

The cultural wealth perspective discusses that communities of color have existing assets rooted from their culture and community that can be leveraged to counter the effects of systemic racism (Yosso, 2005). Influenced by Critical Race Theory (CRT), cultural wealth shifts from a deficit perspective that critiques communities of color of lacking culture and capital because of their illiteracy and inaccessibility to information and institutions entrenched in white middle class heteronormative experiences. Instead, cultural wealth is a strength-based approach and

values the knowledge and experiences of communities of color. Cultural wealth is consisted of six forms of capital that are complex and interrelated: aspirational, navigational, social, linguistic, familial, and resistant (Yosso, 2005). Aspirational capital refers to goals and hopes that family and community members maintain for one another despite institutional and systemic challenges. Linguistic capital is the linguistic, visual, auditory, and communication skills present in the culture and communities that people come from. Familial capital is the cultural knowledge learned by individuals from their proximal, extended, and chosen kin that shape their emotional, moral, and aspirational consciousness. Social capital is the system and community that provides numerous types of essential and critical support to help individuals navigate institutions. Navigational capital is the skills provided by familial and social capital to help people navigate racist institutions and structures. Finally, resistant capital pertains as verbal and nonverbal cues, values of self-worth and reliance, and the development of critical consciousness as oppositional behaviors and attitudes to oppose and survive. Through a combination of these factors, cultural wealth allows for scholars to teach, research, and implement programs with the objectives of social and racial justice. While this perspective has mainly been established to focus within the field of education concerning pedagogy, praxis, and retention (Espino, 2014; Liou et al., 2016); cultural wealth can also be applied in other fields including public health (Manzo et al., 2017) and social work (Olcoń et al., 2018) to inform effective practices. Since the strength-based perspective is a core tenet of social work practice, the cultural wealth approach provides a framework to highlight and help identify assets within the community and experiences of care workers.

Critical Feminist Perspective

Care work is gendered because of patriarchy and capitalism that promulgated policies and values that relegated women to the home and the duties associated within this sphere (Gimenez, 2005). As a result of the industrial revolution, though it can be argued that womxn of color have always worked, womxn were subjected to double day jobs of participating in the work sector and also providing care to their family once they return home (Boris & Fish, 2014). Marxist theory deems that production is one of the main objective of society and reproductive labor allows for the maintenance and fabrication of a labor force through the completion of the tasks and duties in the home (Duffy, 2011). The supposition that it is the natural role of womxn to perform these roles justified care work as unpaid. Feminist scholars instead argued that reproductive labor is an integral aspect of the industrial economy, and thus, must be recognized as legitimate work (Duffy, 2011). However, within the concept of care work tensions and schisms also exist. Integrating racism in understanding care work demonstrates that racism created racial division that stratified white womxn and womxn of color into positions that allows the former to hire the latter and be able to take on leisure and professionalized careers while the latter is left to do the "dirty work" that maintains the home (Chang, 2016; Glenn, 1992). Moreover, residues of imperialism also allowed to shape and mold a constant supply of care workers to protect and care for white bodies (Rodriguez, 2010). Thus, while care work disproportionately affects womxn, disparities subsist through the intricate interactions of ideas and constructs.

Chapter III. Workplace Discrimination and Short Sleep among Healthcare Workers: The Buffering Effect of People-Oriented Culture

Introduction

Workers experience numerous types of psychosocial risks in the workplace. These risks include bullying (Sabbath, Williams, et al., 2018), physical violence (Miranda et al., 2011), and sexual harassment (Chirico et al., 2019). A significant form of risk that workers experience is discrimination (Okechukwu et al., 2014). Discrimination is defined as the unfair treatment and negative actions towards an individual or group based on their race, gender, age, disability, etc. (Okechukwu et al., 2014). Beyond interpersonal actions, discrimination can also manifest in institutional and organizational policies that disenfranchise specific groups of people (Bobbitt-Zeher, 2011). In 2017, the United States (U.S.) Equal Employment Opportunity Commission (EEOC) reported that at least 84,254 workplace discrimination charges were filed with the government agency (U.S. Equal Employment and Opportunity Commission, 2018). Researchers suggest that these statistics are often underreported because of numerous reasons such as unclear definitions of what constitutes as discrimination, fear of retribution, lack of management accountability, and institutional barriers (Nadal et al., 2014; J. P. Phillips, 2016).

Discrimination has been associated with numerous negative health outcomes like depressive symptoms (Marchiondo et al., 2017), substance use (Rospenda et al., 2009), and burnout (Khamisa et al., 2013). With the aging of the Baby Boomer population, the U.S. is expected to have at least 1.05 million job openings for nurses by 2022 (Snavely, 2016) suggesting a diversified workforce to fill the demand. Moreover, since Donald Trump's election into office there has been an upsurge of discrimination-related occurrences among minority

groups in the U.S. (Wray-Lake et al., 2018). Thus, there is an increased possibility that specific healthcare workers will continue to experience discrimination.

Discrimination in healthcare settings

Discrimination is prominent in healthcare settings (Baptiste, 2015). Some healthcare workers experience discrimination from patients, the patients' family members, and co-workers because of their race, ethnicity, skin color, accent, disability, gender, sexual orientation, low-wage job title – to name a few (Eliason et al., 2011; Neal-Boylan & Guillett, 2008; Squillace et al., 2009; Travers et al., 2019; R. M. Wheeler et al., 2014). The intersection of identities also influences biases and discrimination despite occupational status. For instance, in a study of implicit bias among workers in a healthcare facility, it was found that white non-medical doctor/registered nurse staff (e.g. receptionists, phlebotomists, licensed practical nurses) held more pro-white biases than physicians and nurses (Tajeu et al., 2018). These instances of discrimination are the outcome of an enduring history of discrimination in the U.S. that has permeated in many institutions including healthcare settings (Travers et al., 2019).

This issue is crucial particularly since marginalized groups make up the majority of healthcare workers in the U.S. In the healthcare industry, about 25 of the 30 health occupations nationally are performed largely by womxn: 90.4% of registered nurses, 92.2% of medical assistants, 87.2% of home health aides, and 84.6% of personal care aides (U.S. Department of Health and Human Services et al., 2017). While white healthcare workers represent the majority of U.S. healthcare workers, racial differences exist in specific occupations. Among registered nurses, 73.5% are white while 5.7% are Latinx (U.S. Department of Health and Human Services et al., 2017). Among low-wage healthcare occupations (e.g. nursing, home health, and personal aides), people of color make up the majority (U.S. Department of Health and Human Services et

al., 2017). Immigrants are also a growing sector of the healthcare industry. A 2016 survey showed that 16.6% of healthcare workers are non-U.S. born or 1 in 6 (Patel et al., 2018). The influx of foreign healthcare workers in the country has been a result of U.S. colonization and neocolonization (Choy, 2003) as well as the demand of an aging population (Mather et al., 2015). The substantial number of womxn and people of color that comprise the majority of healthcare occupations specifically in the low-wage sector suggest that they are a population susceptible to discrimination in the workplace. With known associations of discrimination and health and well-being, this suggests that healthcare workers are a vulnerable population at-risk for poor health. An understudied relationship of discrimination among healthcare workers is poor sleep quality (Slopen et al., 2016).

Association between discrimination and sleep

The overall U.S. population have been sleeping less in the last decade. According to the National Sleep Foundation (NSF), the recommended number of hours of sleep for adults is seven to eight hours (Hirshkowitz et al., 2015). The percentage of adults in the U.S. that reported short sleep duration, sleeping less than seven hours, increased from 30.9% in 2010 to 35.6% in 2018 (Khubchandani & Price, 2020). Glaring disparities among groups exists with short sleep duration highest among Blacks (45.5%), womxn (35.8%), 45-65 year old age group (37.4%), and those with less than a bachelor's degree (38.8%) (Khubchandani & Price, 2020). Notably, 45% of healthcare support workers and 36.3% of healthcare practitioners reported short sleep duration (Khubchandani & Price, 2020). Several factors may explain poor sleep quality among healthcare workers. Most healthcare settings operate in 24-hour shift schedules with variations in scheduling and control among workers (Savic et al., 2019). A meta-analytic review of studies on permanent and rotating shifts found that workers with permanent schedules reported the highest

frequency of sleep duration while those who work in rotating shifts reported the least number of sleep duration (Pilcher et al., 2000). Economic pressure and low-wages may also lead some healthcare workers to work a second job which lessens the number of hours they sleep per day (Caruso, 2014). These circumstances and experiences of discrimination in the workplace may provide insight of how discrimination is associated with sleep.

Discrimination is associated with poor sleep quality (Slopen et al., 2016). Discrimination affects sleep hygiene that may cause daytime sleepiness (Alcántara et al., 2017), poor sleep quality (Majeno et al., 2018), insomnia (Greenberg, 2006), and fatigue (Grandner et al., 2012). Several factors may explain the mechanisms in which experiences of discrimination influences poor sleep. Individuals who experience chronic discrimination may develop hypervigilance because of the constant anticipation of experiencing discrimination which disrupts their sleep and can influence increased high blood pressure (Slopen et al., 2016) that places individuals at higher risk for cardiovascular disease (Doyle et al., 2019). Some individuals are ostracized because of their identity related to their race or ethnicity that engenders feelings of not belonging which has been associated with psychological distress that may affect sleep quality (Huynh & Gillen-O'Neel, 2013). These experiences may affect the performance of healthcare workers in the workplace. Previous studies show that inadequate and inconsistent sleep among healthcare workers is associated with trouble communicating with co-workers (Ovayolu et al., 2014), poor diet (Sorensen et al., 2016), obesity (Nelson et al., 2014), increased work-family conflict (Jacobsen, Reme, Sembajwe, Hopcia, Stoddard, et al., 2014), and functional limitation (Buxton et al., 2012) which can place the worker and patients at risk for increased medical errors and injuries.

Organizational policies and practices as buffers from discrimination

Job resources like organizational policies and practices can potentially act as a buffer from the effects of discrimination. Buffering has been used in health and social science research as a factor that protects or lessens the negative effects of another factor such as a stressful event (Cohen & Wills, 1985). Since most workplaces operate in a top-down approach guided by the guidelines or protocols set forth by the administration, policies and practices have considerable influence in the daily interactions of workers and consumers in the workplace. Indeed, many organizations have adapted variations of policies and practices to alleviate forms of abuse from arising. For instance, there are two domineering strategic approaches in eliminating discrimination in the workplace: the colorblind approach and multiculturalism. The colorblind approach seeks to eradicate discrimination by providing equal opportunity for everyone, instead, it fosters further discrimination by ignoring systemic inequalities and pressures the minority group to assimilate into the dominant group (Liberman, 2013). The multicultural approach acknowledges differences among people and values various identities that people identify with (Liberman, 2013). This perspective, nonetheless, have received resistance from highly identified white employees who perceive multiculturalism as exclusionary to them and engenders prejudice towards their non-white co-workers (Liberman, 2013). Researchers suggest that some forms of policies and practices that organizations and workplaces can employ to eliminate workplace-related discrimination are targeted recruitment, using selection criteria that have less subgroup differences during the hiring process, integrate diversity-related practices in the workplace supported and modeled by the management rather than one-time diversity trainings, and equal pay (Lindsey et al., 2013).

The phrase “nurses eat their young” has plagued the nursing profession for decades, depicting that older and more experienced nurses tend to bully and instigate incivility among

younger and newly hired nurses (Sauer, 2012). Therefore, a workplace environment that fosters a people-oriented culture can potentially alleviate the effects of incivility and discrimination in the workplace. People-oriented culture pertains to the customs and practices in the workplace environment that develops cooperation and trust among the administrative staff and workers, involve workers in the decision-making process, and transparency through open communication (Amick et al., 2000). People-oriented culture has been examined in healthcare settings, demonstrating that healthcare workers who perceive lower people-oriented culture in their workplace are associated with obesity (Nelson et al., 2014) and poor sleep quality (Sorensen et al., 2011) among workers while high perceptions of people-oriented culture are associated with less psychological distress and mental health expenditures (López Gómez et al., 2019). Because previous studies demonstrate that healthcare workers experience discrimination from patients and their co-workers alike (Eliason et al., 2011; Neal-Boylan & Guillett, 2008; R. M. Wheeler et al., 2014), the role of people-oriented culture among colleagues can potentially assuage the effects of discrimination. However, it is also possible that people-oriented culture can also exacerbate short sleep as associated with discrimination especially in workplace settings where workers have low inter-cultural training and understanding which has been found as a barrier to building trust and communication in the workplace (R. Y. J. Chua & Morris, 2009). The healthcare setting in the U.S. is becoming more diversified in aspects of race, gender, and immigration status, which can be a deterrent to developing a people-oriented culture working environment.

Current study

While discrimination and poor sleep quality among healthcare workers have been examined separately, there is little research that specifically examines how discrimination

experienced by the healthcare worker population is associated with poor sleep quality. Moreover, little is known about how the workplace environment can buffer the effects of discrimination to improve sleep quality outcomes within this population. The purpose of this article is to 1) evaluate the associations of discrimination and short sleep duration among healthcare workers and determine if people-oriented culture buffer poor sleep outcomes, 2) identify how discrimination manifests and who are the perpetrators in the workplace, and 3) appraise how people-oriented culture is constructed and the extent to which it addresses discrimination which can influence short sleep duration among healthcare workers. Study results can help healthcare administrators and social workers understand how the workplace environment affects sleep outcomes among workers in relation to experiences of discrimination. Furthermore, it can help inform the development of people-oriented culture programs and resources that address discrimination at work.

Theoretical Frameworks

Job Demands & Resources Model (JD-R Model)

The Job Demands & Resources Model (JD-R) argues that sustained job demands and inadequate job resources precedes to job strain and poor organizational outcomes (Demerouti et al., 2001). Job demands pertain to labor that require chronic physiological, emotional, and mental exertion. However, effective job resources such as coworker support and autonomy can mitigate job strain and engender motivation and commitment among workers (Demerouti et al., 2001). Various studies have demonstrated that effective job resources can help lessen poor health among healthcare workers (Dehring et al., 2018; Tveito et al., 2014). However, it is also possible that while healthcare workers work in the same institution, policies may differ in departments which can prompt varying forms of job strain or motivation (Sabbath, Sparer, et al., 2018). The

model can inform if job resources that address discrimination exists in the workplace that can potentially influence the sleep quality of healthcare workers.

Social Dominance Theory

Social Dominance Theory (SDT) postulate that inequalities exist because society arranges itself in group-based social hierarchies implemented through institutions, ideologies, and relationships (Sidanius et al., 2004; Sidanius & Pratto, 2012). Members of the dominant group allocate and maintain resources through ideologies and institutions that systematically favors them while members of the subordinate group deal with undesirable oppressive factors (Sidanius & Pratto, 2012). However, a system of balance of hierarchy attenuating ideologies and institutions (e.g. charities, civil rights organizations, etc.) challenge hierarchy enhancing ideologies (e.g. stereotype, representation) and institutions (e.g. criminal justice system, education) (Sidanius & Pratto, 2012). Within the context of the U.S., systems of power have been maintained by and benefits white, cisgender heterosexual males, and middle- and upper-class individuals; although the intersections of identities and certain settings can also complicate and shift power. SDT can help inform the experiences of healthcare workers as their race, gender, sexual orientation, etc. can place them at a disadvantage through discriminating interpersonal interactions, implicit biases, and institutionally reinforced inequity that affect their sleep outcomes.

Methods

Participants

This data employed a mixed-methods approach using an explanatory sequential design. Quantitative data was first collected and analyzed which informed the objectives of the

qualitative data to help further understand the findings of the quantitative results (Creswell, 2015).

For the quantitative portion of the article, we used data from the Boston Hospital Workers Health Study (BHWHS), a longitudinal study that was established in 2006 to examine the working organization and condition, behaviors, and health outcomes among healthcare workers from two large hospitals in the same health system in Boston (Sabbath et al., 2018). The study uses employee databases and surveys collected periodically and linked at the individual worker level. Employees who are categorized as "patient care service" workers are automatically registered in the study ensuring 100% participation until employment termination occurs. In 2017, BHWHS had 8,200 participants in the sample (Sabbath et al., 2018). This study will use the 2018 data which surveyed about 2,000 workers and had a 55% response rate. The initial sample was N=1,101. After eliminating observations with missing cases on key variables short sleep (n=41), discrimination (n=92), and people-oriented culture (n=123), our final sample size for this paper is N=845. Participants received a $10 gift card for participation.

For the qualitative portion of the study, we took the mean people-oriented culture score among all individuals in the hospital units who responded to the survey; the study included workers from 25 units. Using this aggregated data, we determined which nine units had the highest (best) mean people-oriented culture scores and which nine units had the lowest (worst) mean scores. We then contacted the nurse directors of each of those units, 16 agreed to be interviewed. Seven nurse directors managed more than one unit. From this group, we conducted 16 semi-structured interviews (eight from units with high people-oriented culture and eight from units with low people-oriented culture). Two nurse directors were managing units that scored both high and low in people-oriented culture. A trained researcher conducted semi-structured 30-

minute interviews using an audio recorder. Interviews took place in private offices of nurse directors in their units from April through May 2019. Participants were asked questions about unit-level scheduling of workers, breaks, social support and resources, and abuse and harassment. Interviews were transcribed and de-identified. This present analysis focused on data relevant to discrimination and people-oriented culture in relation to short sleep duration. Participants received a $50 gift card for participation.

Measures

Short sleep duration (dependent variable): The outcome variable of interest is short sleep duration measured using the Pittsburgh Sleep Quality Index (Buysse et al., 1989). Participants were asked "Over the past 4 weeks, how many hours do you think you actually slept each night (or day if you work at night)? This may be different than the number of hours you spent in bed." Responses were recorded as continuous variables. To measure short sleep duration, responses were dichotomized categorizing 6 hours of sleep or less as "Yes" and more than 6 hours of sleep as "No." This cutoff is consistent with previous studies (Buxton et al., 2012; Jacobsen et al., 2014). There is no general consensus on how short sleep is measured, other studies have measured short sleep between 5 to 6 hours of sleep or less, and some even less than 8 hours (Consensus Conference Panel et al., 2015). Using 6 hours or less is a meaningful threshold because between 1985 and 2012, the number of U.S. adults that sleep 6 hours or less increased from 38.6 million to 70.1 million (Ford et al., 2015). Numerous other studies also found associations of increase likelihood of developing poor health (e.g. cardiovascular, cancer, mental health, etc.) among adults who slept 6 hours or less (Consensus Conference Panel et al., 2015).

Main Exposure Variables:

Discrimination

The measure used to evaluate discrimination was informed from a previous study (Sternthal et al., 2011). Five questions (Cronbach's α for internal consistency reliability=0.79) were asked on experiences of discrimination assessed on a five-point Likert scale (Never, Less than once a year, A few times a year, A few times a month, or Once a week or more). Participants were asked the following questions: "How often do you feel that you have to work twice as hard as others to get the same treatment or evaluation?" "How often are you watched more closely than other workers?" "How often are you unfairly humiliated in front of others at work?" "How often do people act as if they think you are not smart?" and "How often do people act as if they are afraid of you?" We calculated the mean average scores of the five items for analysis with a minimum range of 0 and maximum of 5. In addition, participants who answered "a few times a year" to at least one of the questions in the discrimination variable, they were asked to answer, "What do you think is the main reason for these experiences?" participants were instructed to only choose one category (e.g. ancestry or national origins, gender, age, etc.).

People-Oriented Culture

People-oriented culture was used as the buffering measure for the study. Four questions (Cronbach's α=.82) were asked about people-oriented culture which pertains to cooperation within a workgroup (Amick et al., 2000). Responses were recorded on a five-point Likert scale (Strongly Disagree – Strongly Agree). An example question that was asked is "Employees on my home unit are involved in decisions affecting their daily work." We calculated the mean average scores of the four items for analysis with a minimum range of 0 and maximum of 5.

Covariates: Age (<30, 30-39, 40-49, and 50+ years old), gender (men and womxn), race (white, Black, Latinx, and Asian American, Native American, and mixed race categorized as other), immigrant status (U.S. born and non-U.S. born), job title (nurse, patient care associate (PCA),

nursing director, assistant nursing director, and clinical nurse manager/supervisor categorized as other), and number of hours worked per week (continuous) were used as control variables. All were self-reported.

Statistical Analyses

Univariate analysis examined the descriptive distribution of the variables. We then compared the variables by short sleep duration using chi-square tests for categorical variables and t-tests for continuous variables. Four models are presented using logistic regression to examine the odds of reporting short sleep duration in association with experiencing discrimination adjusting progressively for the presented covariates. Model 1 examined the associations of experiences of discrimination and short sleep duration. In model 2, including the discrimination variable, we adjusted for people-oriented culture. In model 3, including the discrimination and people-oriented culture variables, we adjusted for socio-demographic variables (e.g. age, gender, race, immigrant status, & job title) and in model 4, which is the full model, including all of the previous variables mentioned (discrimination, people-oriented culture, and socio-demographic variables), we adjusted for number of hours worked per week. Interactions between discrimination and people-oriented culture were tested to determine if people-oriented culture moderated the effects of discrimination on short sleep duration. Observations are non-independent since workers are clustered within units, so we accounted for this clustering by including hospital units as random effects using the "vce (cluster)" command. Missing cases were handled using listwise deletion. Data was analyzed using Stata 15 SE.

Qualitative Analysis

Qualitative data was analyzed using a combination of grounded theory (Strauss & Corbin, 1997) and thematic analysis (Saldaña, 2009). We employed solo coding by following

Saldaña's (2009) recommendations which required consulting with another trained researcher during the progress of the data analysis to discuss, process, and validate the findings. In addition, the coder also kept memos during data analysis. First the trained researcher began with open or initial coding of transcripts to generate a list of codes. Codes were analyzed which facilitated the creation of categories and sub-categories based on patterns from the data. The relationships between categories and sub-categories were assessed that established themes related to perceived experiences of discrimination in the workplace and the operationalization of people-oriented culture. Data was analyzed using Atlas.ti 8.0.

Point of Integration

The point of integration is when components of the quantitative and qualitative findings intersect or merge (Creswell, 2015). In this study, the point of integration occurred in its design and in the analysis. We used data from the qualitative findings to address gaps from the quantitative data concerning aspects of discrimination that healthcare workers experience and how people-oriented culture the extent to which it addresses discrimination that can potentially influence sleep outcomes.

Results

Table 1 presents demographic characteristics of the sample. Of the 845 workers in the sample 83.55% identified as white, 93.02% are womxn, 86.27% are nurses, 29.3% are within the ages of 30-39 years old, 84.85% are born in the U.S., and on average workers worked 36.81 (SD=8.08) hours per week.

Eighty-one percent of the workers reported that they slept for six or more hours per night. On a scale of 1 (Never) to 5 (Once a week or more), the mean experiences of discrimination among workers was 1.57 (SD=.73) meaning that when averaging across all items, respondents

reported experiencing discrimination somewhere between never to once a year. For people-oriented culture, on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree), the mean was 3.74 (SD=.70) meaning that averaging across all items, higher scores corresponded to higher perception of people-oriented culture. Chi-square tests showed that race ($p<.006$) was significantly associated with short sleep duration. The t-tests showed that there are significant differences between discrimination, people-oriented culture, hours worked per week, and short sleep duration.

Table 1. Demographic characteristics of sample. (N=845) [SD=standard deviation].

	Observations (%) or Mean ± SD	Observations of Short Sleep Duration Yes (%)	Observations of Short Sleep Duration No (%)	p[a]
Short Sleep				
No	686 (81.18)			
Yes	159 (18.82)			
Discrimination (1=5; higher=more frequent)	1.57 ± .73[b]	1.57 ± .87	1.53 ± .68	<.001
People Oriented Culture (1=5; higher=better)	3.74 ± .70[b]	3.54 ± .74	3.79 ± .69	<.001
Age				.894
<30	246 (29.11)	46 (18.70)	200(81.30)	
30-39	247 (29.23)	48 (19.43)	199 (80.57)	
40-49	144 (17.04)	24(16.67)	120 (83.33)	
50+	208 (24.62)	41(19.71)	167(80.29)	
Gender				.756
Men	59 (6.98)	12(20.34)	47(79.66)	
Womxn	786 (93.02)	147(18.70)	639(81.30)	
Race				<.01
White	706 (83.55)	118(16.71)	588(83.29)	
Black	65 (7.69)	19(29.23)	46(70.77)	
Latinx	35 (4.14)	10(28.57)	25(71.43)	

Other	39 (4.62)	12(30.77)	27(69.23)	
Education[c]				.091
High School or Less	21 (2.49)	6(28.57)	15(71.43)	
Some College	90 (10.69)	22(24.44)	68(75.56)	
College Graduate	592 (70.31)	99(16.72)	493(83.28)	
Graduate School	139 (16.51)	32(23.02)	107(76.98)	
Immigrant Status				.228
U.S. Born	717 (84.85)	130(18.13)	587(81.87)	
Non-U.S. Born	128 (15.15)	29(22.66)	99(77.34)	
Job Title				.343
Nurse	729 (86.27)	135(18.52)	594(81.48)	
PCA	79 (9.35)	19(24.05)	60(75.95)	
Other (e.g. nursing director)	37 (4.38)	5(13.51)	32(84.49)	
Hours Worked Per Week	36.81 ± 8.08[b]	38.79 ± 8.70	36.35 ± 7.86	<.001

a. P-values of Chi-square for categorical variables and t-tests for continuous variables.
b. Mean values for respective variables.
c. The total sample size for the variable education after omitting missing cases is N=842. Only the descriptive of the education variable is being reported but not used in the analysis.

Table 2 presents the reasons for experiences of discrimination. Among healthcare workers that reported experiencing discrimination, the most prominent reason why they think they experienced discrimination is because of their education or income level (58%), age (16%), and sexual orientation (12%).

Table 2. Reason for experiences of discrimination. (n=360)

Reason	Observations (%)
Ancestry or national origins	9 (2.50)
Gender	16 (4.44)
Race	17 (4.72)
Age	59 (16.39)
Religion	0
Height	0
Weight	3 (.83)

Some other aspect of physical appearance	2 (.56)
Sexual orientation	44 (12.22)
Education or income level	210 (58.33)

Table 3 presents binary logistic regression results. In model 1 there is a significant positive association between experiences of discrimination (OR=1.48, 95% CI=1.23, 1.80) and short sleep duration meaning that a one unit increase in experiences of discrimination is associated with a 48% increased odds of short sleep duration. When adjusting for people-oriented culture (Model 2), experiences of discrimination was attenuated (OR=1.31, 95% CI=1.06, 1.63) and was statistically significant along with people-oriented culture (OR=.68, 95% CI=.53,.87) meaning that a one unit increase in experiences of discrimination is associated with a 31% increased odds of short sleep duration and a one unit increase in perceived people-oriented culture in the workplace is associated with a 32% decreased odds of short sleep duration.

When adjusting for socio-demographic variables (Model 3), experiences of discrimination were further attenuated and remained statistically significant (OR=1.25, 95% CI= 1.00, 1.56) in increased odds of reporting short sleep duration. People-oriented culture also had a significant OR of .66 (95% CI=.51-.85). In the fully adjusted model (Model 4) that included discrimination, people-oriented culture, socio-demographic, and hours worked per week variables, experiences of discrimination (OR=1.23, 95% CI=.98,1.54) were attenuated but no longer statistically significant. However, people-oriented culture continues to have a significant OR of .65 (95% CI=.50-.85), meaning that higher perception of people-oriented culture in the workplace has a significant association in reducing the odds of short sleep duration within the sample.

In the fully adjusted models, workers racially categorized as Asian, Native American, and mixed race had twice the odds of reporting short sleep duration (OR=2.46, 95% CI=1.03,5.83)

compared with white workers and was statistically significant. Similarly, individuals that worked more hours per week had increased odds of reporting short sleep duration (OR=1.04, 95% CI=1.01,1.06) and was statistically significant compared to their co-workers that worked less hours during the week.

Table 3. Logistic regression modeling of relationship of workplace discrimination and short sleep duration. [OR=odds ratio; 95% CI= 95% confidence interval.]

	Model 1 OR(95% CI)	Model 2 OR(95% CI)	Model 3 OR(95% CI)	Model 4 OR(95% CI)
Discrimination (1=5; higher=more frequent)	1.48(1.23,1.80)***	1.31(1.06,1.63)*	1.25(1.00,1.56)*	1.23(.98,1.54)
People Oriented Culture (1-5; higher=better)		.68(.53,.87)**	.66(.51,.85)***	.65(.50,.85)***
Age (ref <30)				
30-39			.96(.57,1.60)	1.05(.63,1.76)
40-49			.73(.45,1.20)	.90(.54,1.49)
50+			.95(.58,1.55)	1.03(.63,1.68)
Gender (ref Men)				
Womxn			1.02(.57,1.84)	1.15(.63,2.08)
Race (ref White)				
Black			2.20(1.01,4.80)*	2.08(.93,4.63)
Latinx			2.01(.83,4.87)	1.79(.72,4.47)
Other			2.53(1.06,6.02)*	2.45(1.03,5.83)*
Immigrant Status (ref U.S. Born)				
Non-U.S. Born			.94(.51,1.74)	.88(.46,1.67)
Job Title (ref Nurse)				
PCA			.85(.47,1.53)	.84(.46,1.54)
Other (e.g. nursing director)			.55(.25,1.21)	.47(.22,.97)*
Hours Worked Per Week				1.04(1.01,1.06)**

*p < .05, **p < .01, ***p < .001

Table 4 presents the interaction terms. We tested the interaction between discrimination and people-oriented culture on short sleep duration. While the main effects of discrimination (OR=1.30, 95% CI:1.02, 1.66) and people-oriented culture (OR=.69; 95% CI:.53,.88) were statistically significant, people-oriented culture did not moderate the effect of discrimination on short sleep duration (OR=.98, 95% CI= .79,1.20).

We conducted sensitivity analyses in which sleep was analyzed continuously instead of dichotomously. Although our findings showed no substantive differences between the two types of outcomes, we chose a binary approach because of ease of interpretation. Results for the sensitivity analyses are available on Appendix A. In addition, we also tested for supervisor and co-worker support as additional constructs of interpersonal organizational policies and practices but did not find any significant association in reporting short sleep duration, the results can be found on Appendix B. Additionally, we also created two different variables of discrimination, three items (Cronbach's α=.76) that are work-related ("How often do you feel that you have to work twice as hard as others to get the same treatment or evaluation?" "How often are you watched more closely than other workers?" "How often are you unfairly humiliated in front of others at work?") and two items (Cronbach's α=.42) that are non-work-related ("How often do people act as if they think you are not smart?" and "How often do people act as if they are afraid of you?"). The findings using the work-related discrimination variable (Appendix C) is comparable to the findings using the full five item scale while the findings for the non-work-related discrimination variable (Appendix D) lost statistical significance for models 2 and 3 concerning the association of discrimination and short sleep duration. This finding suggest that short sleep duration is associated with work-related discrimination compared to non-work related discrimination.

Table 4. Interaction terms between discrimination and people-oriented culture. [OR=odds ratio; 95% CI= 95% confidence interval.]

	OR(95% CI)
Discrimination	1.30(1.02,1.66)**
People Oriented Culture	.69(.53,.88)*
Discrimination x People Oriented Culture	.98(.79,1.20)

*p < .05, **p < .01, ***p < .001

Qualitative analysis

Our quantitative findings show that discrimination is significantly associated with short sleep duration for all the models but model 4. This indicates that the association of discrimination and short sleep duration has its limitations quantitatively. However, people-oriented culture did not buffer the effect of discrimination on short sleep duration. But the independent effect of the association of people-oriented culture and short sleep duration was significant and showed that healthcare workers with perceived high people-oriented culture in the workplace had decreased odds of short sleep duration. In addition, people-oriented culture slightly attenuated the association of discrimination and short sleep duration. While we know the perceived reasons why healthcare workers deem why they were discriminated, we need to further understand the mechanisms in which discrimination transpires and who commits these behaviors in the workplace. Moreover, while people-oriented culture is significantly associated with short sleep duration, we do not know why people-oriented culture did not moderate the effects of discrimination on short sleep. Thus, we want to examine how people-oriented culture is constructed and what it addresses in relation to discrimination to the extent that it can influence the quality of sleep among healthcare workers.

Discrimination and people-oriented culture were not explicitly asked in the study. But through the semi-structured design of the qualitative study and grounded theory, themes of discrimination and people-oriented culture emerged in the study. It is important to note that only

9 out of 16 (56%) hospital unit nurse directors explicitly identified a form of discrimination that they perceive their co-workers experienced. Of the nine unit nurse directors, six were from units that scored high in people-oriented culture and three were from units that scored low in people-oriented culture. However, one of the unit nurse directors was counted twice because they managed two units that scored both high and low in people-oriented culture.

Discrimination

The unit nurse directors discussed many forms of violence that nurses and PCAs experience including abuse, harassment, bullying, and discrimination from their co-workers, patients, and their family members, however, our study aimed to focus on discrimination which is distinct from the other forms of violence mentioned.

Discrimination transpired among co-workers because of job titles. Participants discussed that discrimination occurs hierarchically among co-workers in relation to their job titles. The quantitative results showed that 58% of nurses and PCAs reported experiencing perceived discrimination due to their education or income level. Their job titles are reflective of their education and income levels. These job titles entail varying responsibilities, demands, and prestige in how people perceive them. Thus, sentiments of feeling disrespected occur particularly among PCAs who may feel undermined because of their job status. Several unit directors shared that the hospital recently conducted a hospital-wide survey and found that PCAs don't feel respected:

> …we actually just did a PCA survey and part of what they expressed was not feeling as respected as a role group, as nursing does, which I can see. So we try to include them and to make sure that when it's a nursing – I address them as a team and everyone together, but I know that they definitely don't feel entrenched in that nursing culture the way that the nurses do. (#8, high in people-oriented culture)

Feeling disrespected may be a result of poor knowledge of the demands that healthcare workers are experiencing which are not being communicated to their co-workers. Unit nurse directors shared that many of the workers in their units are inundated with their own job responsibilities and at-times are not able to verbalize to their co-workers their own expectations of them or tasks that they need to be completed. In turn, co-workers discriminate against one another in relation to the duties associated with their job titles:

> … the nurses feel that the PCAs can help more with toileting the patients, so that they don't fall. And that – and then the PCAs feel that the nurses can help them more instead of calling them for every toileting and for every patient call. If they're like just in the computer like sitting down, they should also be helping more. And then, the unit coordinators feel that the nurses talk to them in an unprofessional way and the nurses feel that the unit coordinators just sits down and they have more – they have more abilities to help out more. (#2, high in people-oriented culture)

While nurses and PCAs shared their own feelings of being discriminated, unit nurse directors also internalize discriminating thoughts about their co-workers that may affect how they interact with PCAs. Unit nurse directors expect a sense of professionalism from their co-workers that lead them to assume that the environment in which some of their workers are from are not equipping them with professional skills:

> One of the things that I think is just – and I hate to even say it, but it's the truth and this is what it is. And I think, a lot of times, folks who come into those career PCA roles are not always coming from environments that are professional environments. A workforce – a household that comes from a professional environment. So they just sometimes are lacking some of those professional behaviors. (#3, high in people-oriented culture).

Chronic experiences of discrimination may have a long-term effect specifically among PCAs where they begin internalizing these experiences of discrimination which can influence their overall health and well-being. A unit nurse director discussed how one of the PCAs in their units shared with her how they feel about themselves, "…they feel like just because they're poor,

they're Black and they're immigrants – they feel that they're marginalized. That's how they feel." (#2, high in people-oriented culture).

People-Oriented Culture

Numerous resources are available for healthcare workers but these resources do not specifically address discrimination. Numerous programs and resources were identified by the unit nurse directors that their units and the hospital at-large have created over time that foster people-oriented culture. These resources respond to the various needs of healthcare workers ranging from professional training, health and mental health resources, and team building activities. One unit established a series of programs to address the mental health of the workers in their units and develop camaraderie with one another through storytelling:

> And then we've also implemented quiet time in the flight decks. So there's a room up there where it's quiet time, people shouldn't be on their phones, computers or watching TV in that room from 2:00 to 4:00 a.m. and p.m., giving them – the staff two hours where they can go and just kind of just close their eyes, nap, meditate, whatever they want to do but it's got to be quiet – no one's talking. And then we encourage storytelling among them to help them bond and hopefully do some learning about how you took care of a patient or something humorous that happened that just it helps them bond, and then the fourth thing we're doing is tea for the soul, and we do that once a month for the day and night teams when we have our staff meetings. (#13, low in people-oriented culture).

While these programs address mental health and relationship building among healthcare workers, it does not address resources directed to addressing discrimination that can potentially influence other health outcomes such as sleep quality. Interestingly, only one unit nurse director specifically discussed a resource that focused on inclusivity to mitigate discrimination that was difficult for healthcare workers to attend because of scheduling conflict and how often these programs are offered:

> … I think if it's a culture for the hospital to have everyone attend effective communication…like the Unconscious Bias – which I think is good. I think it would be helpful. But…they don't have it on a monthly basis…and they don't

> have the schedule far enough that we can schedule everyone in. (#2, high in people-oriented culture).

Instead, conflict among co-workers that may be related to discrimination in the workplace seems to be managed interpersonally by unit nurse directors:

> If someone is having a bad day and they talk curtly to a peer, that could be a situation. They might come to me and say "I had this interaction with so-and-so today." We do like a little role play of how can you now react to that person? "So let's talk about what you're going to do." We talk all about how it's important not to react in the moment. You know take a deep breath and "maybe talk to them in the next day or later on in the shift, off the unit, in a conference room," that kinda thing. (#15, low in people-oriented culture).

The integration of quantitative and qualitative findings suggests that people-oriented culture focuses on other aspects of health and well-being among co-workers but resources and programs promoting inclusivity related to experiences of discrimination are limited that can potentially influence the sleep quality of healthcare workers.

Discussion

Our mixed methods analysis evaluated the buffering effect of people-oriented culture on short sleep duration. We found that experiences of discrimination among healthcare workers are associated with increased odds of reporting reduced hours of sleep for all the models but the fully adjusted model. However, people-oriented culture did not moderate the effect of discrimination on short sleep duration. Organizational culture, specifically, people-oriented culture among co-workers, slightly attenuated the association between experiences of discrimination and odds of short sleep duration. The qualitative findings show that co-workers experience discrimination vertically because of their job titles. The resources that promote people-oriented culture in the unit seems to address other aspects of the health and well-being of healthcare workers, but there are limited resources available that address discrimination which can potentially influence the sleep quality of healthcare workers.

All models but the fully adjusted model show that experiences of discrimination are associated with increased odds of short sleep duration. This finding is consistent with previous studies on discrimination and poor sleep quality (Slopen et al., 2016; Slopen & Williams, 2014). But after adjusting for hours worked per week, experiences of discrimination were no longer a significant predictor, however, hours worked per week was a significant predictor. A potential explanation is that working longer hours per week and discrimination are correlated. A study among physicians found that frequent experiences of discrimination are associated with burnout (Hu et al., 2019). Studies also found that working longer hours per week also increases the likelihood of burnout among workers (Cheung et al., 2018). Both of these factors may have a similar impact on sleep quality.

The quantitative findings also show that over half of reported experiences of discrimination among nurses and PCAs are related to their education or income level which correspond to the job titles of workers. Previous studies found that job prestige plays a role in influencing discrimination in the workplace between co-workers (Kossek & Lautsch, 2017). The qualitative data helps us understand the quantitative findings by confirming that discrimination is related to the job titles of healthcare workers, specifically targeting low-wage workers such as PCAs. In addition, the qualitative findings also explain our understanding of how discrimination transpires in the workplace, between co-workers which was not captured perhaps due to the measures used in the quantitative data. While the interviews did not discuss how discrimination may influence poor sleep quality, studies on discrimination and sleep (Slopen et al., 2016) suggest that these experiences may have an effect on short sleep duration among healthcare workers, particularly PCAs. Moreover, since the majority of PCAs are from minority groups, chronic experiences of discrimination such as in relation to their race has been associated with

the development of racism-related vigilance (Hicken et al., 2013) and increased levels of stigma consciousness (Ong et al., 2017) among people of color which are associated with poor sleep. Thus, discrimination experienced by PCAs from their co-workers and the internalization of oppression that have been unjustly associated with their identities suggest that future studies need to further understand how discrimination specifically affects PCAs and varying health outcomes including their sleep quality. Discrimination experienced by low-wage healthcare workers is reflective of SDT that illuminates how healthcare workers who may hold more power through their identities such as being white and job prestige of being a nurse compared to a racial minority PCA may explain aspects of oppression occurring in the workplace.

People-oriented culture did not modify the negative influence of discrimination on short sleep duration. Existing research that used the concept of people-oriented culture to assess worker's health and well-being have not examined its influence on discrimination (Biswas et al., 2018; Sabbath, Sparer, et al., 2018). However, people-oriented culture has been associated with improved sleep (Sorensen et al., 2011). The qualitative findings show that while people-oriented culture may focus on other aspects of the working environment and worker's health, the programs and resources implemented related to people-oriented culture are not specifically addressing discrimination which in turn may influence poor sleep among workers. However, people-oriented culture may indirectly address discrimination through the various programs and resources implemented that are relevant to people-oriented culture since our quantitative results showed that people-oriented culture slightly attenuated the association of experiences of discrimination and short sleep duration even when we controlled for our covariates. Past studies found that workplace settings that encourage respect and support among workers mitigate the likelihood of discrimination among minority groups in the workplace (Ruggs et al., 2015;

Stainback et al., 2011). By implementing numerous initiatives and programs focusing on inclusivity and attenuating discrimination and integrated as part of the people-oriented culture of a workplace (García Johnson & Otto, 2019; B. N. Phillips et al., 2016; Szeto & Dobson, 2010) then sleep quality may improve among marginalized groups. The only program mentioned in the qualitative interviews that targeted discrimination is the availability of unconscious bias training in the hospital. However, unconscious or implicit bias trainings taken once have been found to ineffective in reducing biases (C. K. Lai et al., 2016). Scholars argued that in order to change oppressive systems, oppressive structures and systems must be named – racism, sexism, classism, homophobia, transphobia, etc. – to name a few (Bassett, 2017). Perhaps workplace settings can consider offering and mandating on-going trainings that discuss racism and other forms of oppression and establishing tangible changes in the policies and practices in the hospital that shifts the culture of the workplace that can potentially lead to a culture that centers social justice.

Limitations and strengths

A limitation of the study is that experiences of discrimination is self-reported which may indicate potential bias and inaccurate introspection. However, experiences of discrimination perceived by the recipient produces stress which shows that self-report is an appropriate method of measuring discrimination (Pascoe & Smart Richman, 2009; D R Williams et al., 1997; David R Williams et al., 2003). Another limitation is that while our sample is representative of the socio-demographic make-up of nurses in the U.S., it does not reflect the full diversity of the experiences of the healthcare workforce. Nevertheless, gender, sexual orientation, job title, and other factors may explain reasons for experiencing discrimination within this sample. Qualitative interviews were conducted among unit nurse directors which limits the understanding of

experiences of discrimination based on their perceptions that excludes the experiences of nurses and PCAs. The qualitative interviews also did not explicitly asked questions regarding experiences of discrimination and how healthcare workers perceive people-oriented culture which limited our understanding of how these constructs transpired. But the use of grounded theory in the qualitative analysis permitted for themes related to discrimination and people-oriented culture to emerge. Finally, while the study is longitudinal, the 2018 wave was the first time that discrimination was measured in the survey instrument. Thus, this study is cross-sectional in nature and cannot explain causality.

The study has several strengths. Previous studies have analyzed the influence of discrimination on sleep quality and outcomes separately within the healthcare worker population, this study is one of the few that specifically examines the impact of discrimination on a particular sleep outcome, short sleep duration, among healthcare workers. It also assesses the mitigating influence of people-oriented culture in the workplace to diminish the influence of discrimination. A notable strength of the study is our use of a mixed methods approach that permits the triangulation of data to gain a more in-depth understanding of the findings. While discrimination has been ever present in society, the increasing reports of explicit forms of discrimination in the U.S. will continue to affect the health and well-being of marginalized groups. Implementing hierarchy attenuating ideologies and practices in institutions such as organizational policies and practices in the workplace like the importance of cultivating a workplace environment that fosters people-oriented culture that allays the impact of discrimination can improve the health and well-being of healthcare workers which in turn can improve the quality of care being provided to patients.

Conclusion

This paper found that discrimination is associated with short sleep duration among healthcare workers. Experiences of discrimination are experienced hierarchically among co-workers and are related to their job titles. However, people-oriented culture did not buffer the effects of discrimination on short sleep duration. People-oriented culture may be addressing other aspects of the health and well-being of healthcare workers and the working environment but not to the extent that it focuses on mitigating the effects of discrimination which can influence sleep quality.

These findings have some implications on policy and practice. From a policy and practice perspectives, healthcare settings need to implement programs and resources that are targeted towards identifying discriminatory and oppressive structures in the workplace and promoting inclusivity through demonstrable changes in the workplace structure which in turn can improve the sleep quality of healthcare workers. Through these practices, the health and well-being of healthcare workers may improve which can lessen medical errors and enhance patient safety.

Future studies should consider examining specific forms of discrimination and a broader demographic of healthcare workers to evaluate how organizational policies and practices influence the impact of discrimination on their sleep quality.

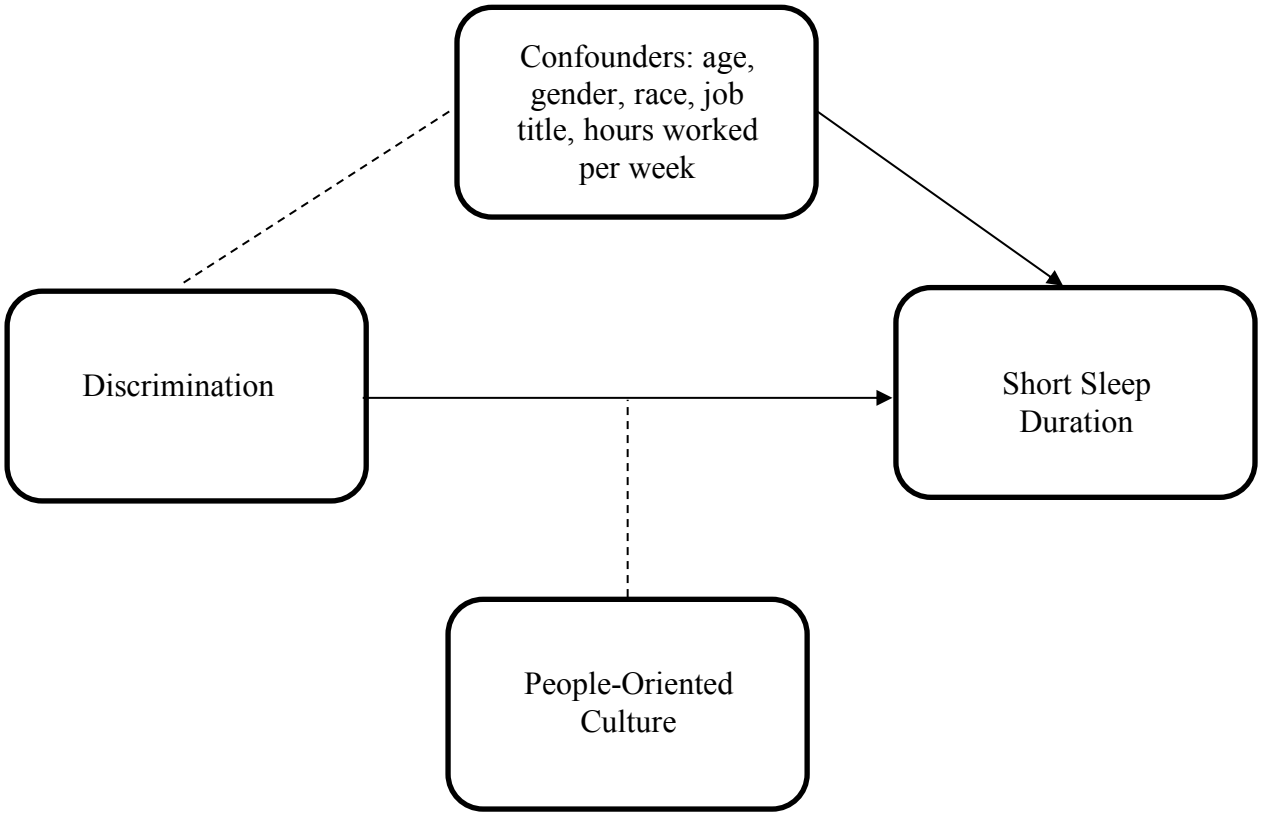

Figure 1. Path Diagram of Discrimination on Sleep Quality Among Healthcare Workers

Chapter IV. Job and Personal Demands and Burnout Among Healthcare Workers: The Moderating Role of Workplace Flexibility

Introduction

Burnout is a concern for workers around the world. In 2019, the World Health Organization (WHO) officially declared burnout as an occupational phenomenon and was included in the 11th edition of the International Classification of Diseases (ICD-11) (World Health Organization, 2019). A U.S. poll reported that among 7,500 full-time employees, close to a quarter reported experiencing burnout very often or always (23%) while almost half reported sometimes (44%) (Wigert & Agrawal, 2018). One of the occupations that experience high rates of burnout are healthcare workers (Medicine & National Academies of Sciences and Medicine, 2019). Whereas national studies examining burnout among healthcare workers are limited, existing studies reveal alarming rates. For instance, among physicians, burnout rates ranged between 40%-54% from 2009 through 2019 while burnout rates among nurses ranged between 35%-45% from 2002 through 2016 (Medicine & National Academies of Sciences and Medicine, 2019). The increasing shortage of healthcare workers due to an aging population (Snavely, 2016) and in light of the recent COVID-19 pandemic (J. Lai et al., 2020; Sasangohar et al., 2020) suggest that healthcare workers will continue to be at high risk for burnout.

Burnout

Burnout is defined as a protracted response to persistent psychosocial and relational-related stressors consisted of three facets: exhaustion, cynicism, and professional inefficacy (Maslach & Leiter, 2016a). Exhaustion pertains to emotional diminution because of interpersonal demands (Schaufeli & Salanova, 2014). Cynicism is the depersonalization of the task and people that individuals interact with (Schaufeli & Salanova, 2014). Personal inefficacy is the sentiment

of feeling inadequacy and low self-esteem when performing and completing tasks (Schaufeli & Salanova, 2014). Decades of research reveal that burnout is associated with six domains of risk factors: work overload, lack of job control, insufficient reward or recognition, poor work collegiality, inequity in decision making, and conflict between worker and organizational values (Maslach & Leiter, 2016b). The presence of these risk factors in the workplace have been associated with job dissatisfaction and reduced organizational commitment among workers (Chowdhury, 2018). Chronic experiences of burnout and limited resources in the workplace increases the intention to leave for workers (Schaufeli, Leiter, et al., 2009). Turnover in organizations can be costly for organizations. For example, physician turnover costs hospitals between $2.6 billion to $6.3 billion each year (Han et al., 2019). The average cost of turnover of nurses for hospitals is $44,400 per nurse, costing hospitals between $3.6 to $6.1 million (NSI Nursing Solutions, 2020). On the individual level, health outcomes associated with burnout among workers include emotional drain (Kelly et al., 2019), less motivation and engagement (Drafahl, 2019), detachment (López-López et al., 2019), and depression (Schonfeld & Bianchi, 2016).

Job Demands

Healthcare workers perform taxing job responsibilities. Most hospitals are organized in nursing units. Each nursing unit may have a range of 20 to 40 beds (Green, 2002). An analysis of 83 hospitals found that on average each nurse is in charge of 5.33 to 6.39 patients while there are usually two Patient Care Associates (PCAs) per unit per shift in charge of all the beds in the unit (Spetz et al., 2008). Nurses are tasked with physical care, administering medication, monitoring patient's status, administrative duties such as documentation and charting, and providing psychological and social needs of not only the patients but their family members and support

network (Morrison & Korol, 2014). Low-wage healthcare workers like Certified Nursing Assistants (CNA) or PCAs provide more physically demanding services such as bathing, feeding, lifting patients, changing bed sheets, and stocking hospital rooms with necessary supplies (Kummeth et al., 2001). Such demands are associated with high rates of injuries and illnesses, an average of 6.0 cases for every 100 employees (Dressner, 2017). These events are associated with negative health outcomes including pain, posttraumatic stress disorder (PTSD), hypervigilance, sleep disturbances, and reduced work functionality (Lanctôt & Guay, 2014). Consequently, high turnover rates are prevalent, particularly among low-wage healthcare workers averaging 14% to 346% annually (Castle, 2006; Cooper et al., 2016; Donoghue, 2009; Trinkoff et al., 2013) compared to their high-wage counterparts such as nurses with 33.5% turnover after two years of becoming nurses (Kovner et al., 2014) due to burnout and emotional and physical exhaustion.

Personal Demands

Another important aspect of the experiences of healthcare workers is the influence of personal demands (Bullock & Waugh, 2004). Personal demands denote private or familial-related responsibilities such as caring for family members and performing familial and household activities (Voydanoff, 2005). However, disparities exist concerning which individuals or groups carry the burden of such demands. For instance, personal demands are often gendered due to patriarchal-imposed roles on women (Blanch & Aluja, 2012; Parreñas, 2001b). Similarly, low-wage workers also experience more demanding job duties, working double jobs, or picking up overtime hours to make ends meet (Devine et al., 2006; Wharton, 2006). Single parents, particularly, single mothers of ethnic minority descent face numerous forms of oppression related to their gender, race, and single-parent status that contribute to the challenges of

balancing the demands of motherhood and working (Richard & Lee, 2019). Studies show that healthcare workers feel a sense of guilt for not being able to perform their familial responsibilities once they arrive home from work because they felt depleted from providing care and empathy not only to their patients but also their patient's family members (Bullock & Waugh, 2004).

Combined Job and Personal Stressors

Personal and job demands are not independent of each other. The stress associated with personal responsibilities such as taking care of family members can permeate to the pressure in the workplace, vice versa, which impacts the job performance and functionality of healthcare workers (Jennings, 2008). Healthcare workers due to the reality with shift-work, and for some inconsistencies in shift-work and lack of control when they can work, are finding themselves stressed in maintaining tight schedules between work and family activities that are intricately performed and oscillated between workers and their working spouses (Bullock & Waugh, 2004; Maher et al., 2010). Other factors may explain further disparities in combined job and personal demands. For instance, while having children can be a stressor, strong family cohesion and larger family size moderate the negative relationship between burnout and recovery (Ugwu et al., 2018). Scholars have also argued that childless workers experience backlash because they are expected to work additional hours or be more flexible with their hours to accommodate their co-workers with rigid schedules because of familial responsibilities (Young, 1999). Research among healthcare workers show that those who experience compounding job and personal demands are more likely to experience sleep deficiency (Jacobsen, Reme, Sembajwe, Hopcia, Stoddard, et al., 2014), musculoskeletal pain (Kim et al., 2013), and burnout (Burke & Greenglass, 2001; Jennings, 2008).

Workplace Flexibility as a Buffer to Job and Personal Demands on Burnout

Organizational policies and practices can potentially mitigate the negative outcomes of job and personal demands on burnout. Studies have shown that job resources like workplace flexibility can alleviate negative health outcomes among healthcare workers due to job and personal demands, although, variations of health outcomes exist dependent on the prestige or title of one's occupation (Tveito et al., 2014). Workplace flexibility is defined as the level of autonomy of workers to have the option to choose the duration, tasks, location, and time that they can execute their job (Jeffrey Hill, Grzywacz, et al., 2008). From the organizational perspective, workplace flexibility can also refer to the ability of organizations to modify aspects and factors in the workplace that prioritizes the profitability of the organization with practices like hiring contract workers, quality circles, and job rotation (Jeffrey Hill, Grzywacz, et al., 2008). A study on patient care workers found that healthcare settings with greater job flexibility and decision latitude are associated with more physical activity among their workers which can prevent overweight and obesity (Nelson et al., 2014). Moreover, another study explored the effects of flexibility, ergonomics, and people-oriented culture among healthcare workers and found significant associations between workplace flexibility and increased visits for preventive care among workers (Sabbath, Sparer, et al., 2018). In studies that examined familial structures in relation to job and personal demands, workplace flexibility, specifically, schedule flexibility, moderated stress among womxn, single parents, and workers with demanding familial responsibilities (Jeffrey Hill, Jacob, et al., 2008; Jung Jang et al., 2012).

Purpose

Previous studies on healthcare workers that evaluated the associations of job and personal demands on burnout among healthcare workers focused on specific occupations independently

(Leineweber et al., 2014; Wang et al., 2012). This article examined the compounding effects of job and personal demands on burnout from a diverse sample of healthcare workers that included both nurses and PCAs which reflects a more accurate depiction of the population of healthcare workers. Furthermore, other studies operationalized personal demands that included relationship status and number of children as separate variables (Cañadas-De la Fuente et al., 2015). This study will examine the familial structures additively and operationalized job demand using the Job Demands-Control model (Karasek, 1979). The purpose of this study is to 1) examine the associations of job and personal demands and workplace flexibility on burnout and 2) evaluate the moderating effect of workplace flexibility and job and personal demands on burnout. Findings from this study can help inform healthcare organizational settings evaluate the efficacy of their organizational policies and practices that can reduce burnout.

Theoretical Framework

Job-Demands Resources (JD-R) model. The Job-Demands Resources (JD-R) model posits that every occupation has specific job risk factors that influences organizational outcomes, including, the well-being of workers (Bakker & Demerouti, 2007). Job demands pertain to the sustained physiological, social, or organizational responsibilities of the job while job resources refer to similar aspects but focuses in helping facilitate and achieve work goals, decrease job demands and its physiological and psychological costs, and cultivate personal development among workers (Bakker & Demerouti, 2007). Workers can experience strain on the job as a result of stressful and exacting job demands but organizations that have effective and accessible job resources can prevent harmful outcomes and encourage motivation among workers. Several studies have used the JD-R model to show how increase in job demands and decrease in job resources predicts burnout among workers (Crawford et al., 2010; Schaufeli, Bakker, et al.,

2009). Workplace flexibility has been shown to lessen the likelihood of burnout (Nelson et al., 2014; Sabbath, Sparer, et al., 2018). Through the JD-R model we can understand how workplace flexibility among healthcare workers can potentially moderate the effect of burnout.

Social Dominance Theory. Social Dominance Theory (SDT) postulates that societies are designed in group-based social hierarchies that preserves the power of the dominant group through the allocation and maintenance of resources and in turn marginalizes minorities (Sidanius et al., 2004; Sidanius & Pratto, 2012). Power is administered through three branches of the system that benefits adults, men, and subjective social categories such as race, religion, social class, etc. (Sidanius & Pratto, 2012). Hierarchy-enhancing ideologies and institutions propagate discriminatory beliefs and ostracizes subordinate groups in various institutions. However, hierarchy-attenuating ideologies and institutions such as charities and civil rights organizations challenge the former. SDT can be employed to understand disparities in healthcare organizations in the health outcomes of their workers. Since previous studies demonstrate that single parent households, particularly single mothers, experience additional stressors related to job and personal demands (Devine et al., 2006; Richard & Lee, 2019; Wharton, 2006), SDT can assist in identifying which groups of healthcare workers are potentially at-risk for the likelihood of burnout in association with their familial structure.

Methods

Participants

Data from the Boston Hospital Workers Health Study (BHWHS) was used for this study. Established in 2006, BHWHS is a longitudinal study of healthcare workers from two large hospitals in Boston that evaluates their workplace organization and condition, behavior, and health outcomes (Sabbath, Hashimoto, et al., 2018). The survey asked a total of 59 questions for

all respondents and an additional two questions for unit supervisors. The study collects data periodically and links both the employee databases and employee surveys at the worker level. Employees categorized as patient care service workers are automatically enrolled in the study until employment termination, however, previous data collected about the employee are kept (Sabbath, Hashimoto, et al., 2018). Surveys are disseminated through email but to increase responses particularly among PCAs, paper surveys were also mailed which increased survey responses by 20%. The 2018 wave surveyed about 2,000 workers with a 55% response rate (N=1,101). After omitting cases with missing observations on key variables burnout (n=78) workplace flexibility (n=74), relationship status (n=108), # of children under 5 (n=116), # of children over 5 (n=132), decision latitude (n=107), demands (n=114) and covariates, we analyzed 874 healthcare workers.

Measures

Burnout. The outcome variable of interest is burnout measured using a single-item question, "How often do you feel burned out from your work? Burnout is a feeling of physical and emotional exhaustion, due to stress from working under difficult or demanding conditions" (West et al., 2012). This single item measure has been validated in other studies focusing on a broad group of healthcare workers such as physicians, nurse practitioners, registered nurses, and medical technicians (Dolan et al., 2015; Shanafelt et al., 2015). Responses were assessed on a 7-point Likert scale (Never, A few times a year or less, Once a month or less, A few times a month, Once a week, A few times a week, Every day). While previous studies (West et al., 2012) show that the outcome variable, burnout, can be measured as binary or ordinal variables, the Brant test that tested proportional odds showed that assumptions were violated. Thus, measuring the outcome as an ordinal variable is inappropriate and using the binary outcome is more

appropriate. We recoded burnout as a dichotomous variable No (Never – A few times per month) and Yes (Once a week – Everyday).

Main Exposure Variables

Personal Demands. The variables included as personal demands are marital status and number of children in the household. The study asked socio-demographic questions where respondents were able to indicate their marital or partnership status. They also reported how many children are over and under 5 years old living with them three or more times during the week. Since previous research showed that familial structures are better indicators of work-family conflict (Blanch & Aluja, 2012; Devine et al., 2006; Richard & Lee, 2019; Wharton, 2006), we recoded the variables and created new categories of family characteristics (single no child, single with child, married no child, and married with child).

Job Demands. Job demands were measured using the Job Content Questionnaire (Karasek et al., 1998). We used the quadrants of job strain as a result of high demand and low control from the Job Demands-Control model (Karasek, 1979). To create this variable, we used the job demand sub-scale where participants were asked 5 questions (Cronbach's α=.74) that assessed how hard and how much time the participant has to perform the task; some questions that were asked are "My job requires working very hard" and "I have enough time to get the job done." Low control was created using a combination of two sub-scales: skill discretion and decision making. For the skill discretion sub-scale, participants were asked 6 questions (Cronbach's α=.71) that assessed if participants are able to develop skills in their work; some questions that were asked are "My job requires that I learn new things" and "My job requires me to be creative." For the decision-making sub-scale, participants were asked 3 questions

(Cronbach's α=.63) about their decision authority at work; a question that was asked is "I have a lot to say about what happens in my job."

All responses were measured in a 5-point Likert scale (Strongly Disagree – Strongly Agree). Mean scores were calculated for the demand and control variables. The median of each variable was used to determine whether the respondent is categorized as high or low on the demand and control variables. For example, if the respondent scored higher than the median for the demand variable, they are categorized in the high demand quadrant while a respondent who scored lower than the median for the control variable is categorized in the low control quadrant. The four job strain quadrants are: high strain (high demand, low control), active (high demand, high control), passive (low demand, low control), and low strain (low demand, high control). High strain pertains to workers who experience demanding job responsibilities with little control in the decision-making of facets of their job, active are workers who have high job demands but have control in the decision-making in facets of their job, passive workers have low job demands but also little control in the decision-making process, and low strain workers have low demands but high control in the decision-making, sometimes relegated to administrators (Karasek, 1979).

Workplace Flexibility. Workplace flexibility policies pertain to the level of independence that workers can perform their job responsibilities. Respondents were asked seven questions (Cronbach's α=.66) informed from a previous study (Thomas & Ganster, 1995) that interrogates their ability to take time off work including vacations, when they work, the number of hours that they work, ability to receive personal phone calls while at work, opportunity to work from home, and if they can switch to a part-time schedule. Responses were measured in a 5-point Likert scale (Very Little – Very Much). We calculated the mean average scores of the seven items for the analysis with a minimum range of 0 and maximum of 5. Previous studies that

used the workplace flexibility scale used the mean average score of the items (Sabbath, Sparer, et al., 2018).

Covariates. Age was modeled as a categorical variable: <30, 30-39, 40-49, and 50+ years old.

Gender was modeled as a binary variable: men and womxn.

Race was modeled as a categorical variable: white, Black, Latinx, and other (Asian American, Native American, and mixed race).

Immigrant status was modeled as a binary variable: U.S. born and non-U.S. born.

Job title was modeled as a categorical variable: nurse, patient care associate, and other (nursing director, assistant nursing director, and clinical nurse manager/supervisor).

Statistical Analyses

Univariate analysis examined the descriptive distribution of the variables. We constructed four models beginning with the associations of family structures and odds of burnout. We adjusted progressively for job demands, workplace flexibility, and covariates. We used binary logistic regressions to examine the associations of work-family conflict and workplace flexibility on odds of burnout. To determine the moderating effect of workplace flexibility, interaction terms between workplace flexibility and job and personal demands on burnout were tested. To assess the differences between personal and job demands on burnout, we also stratified the sample between healthcare workers with perceived low flexibility compared to high flexibility using the mean score and repeated the preceding analyses. Missing cases were handled using listwise deletion. Data was analyzed using Stata 15 SE.

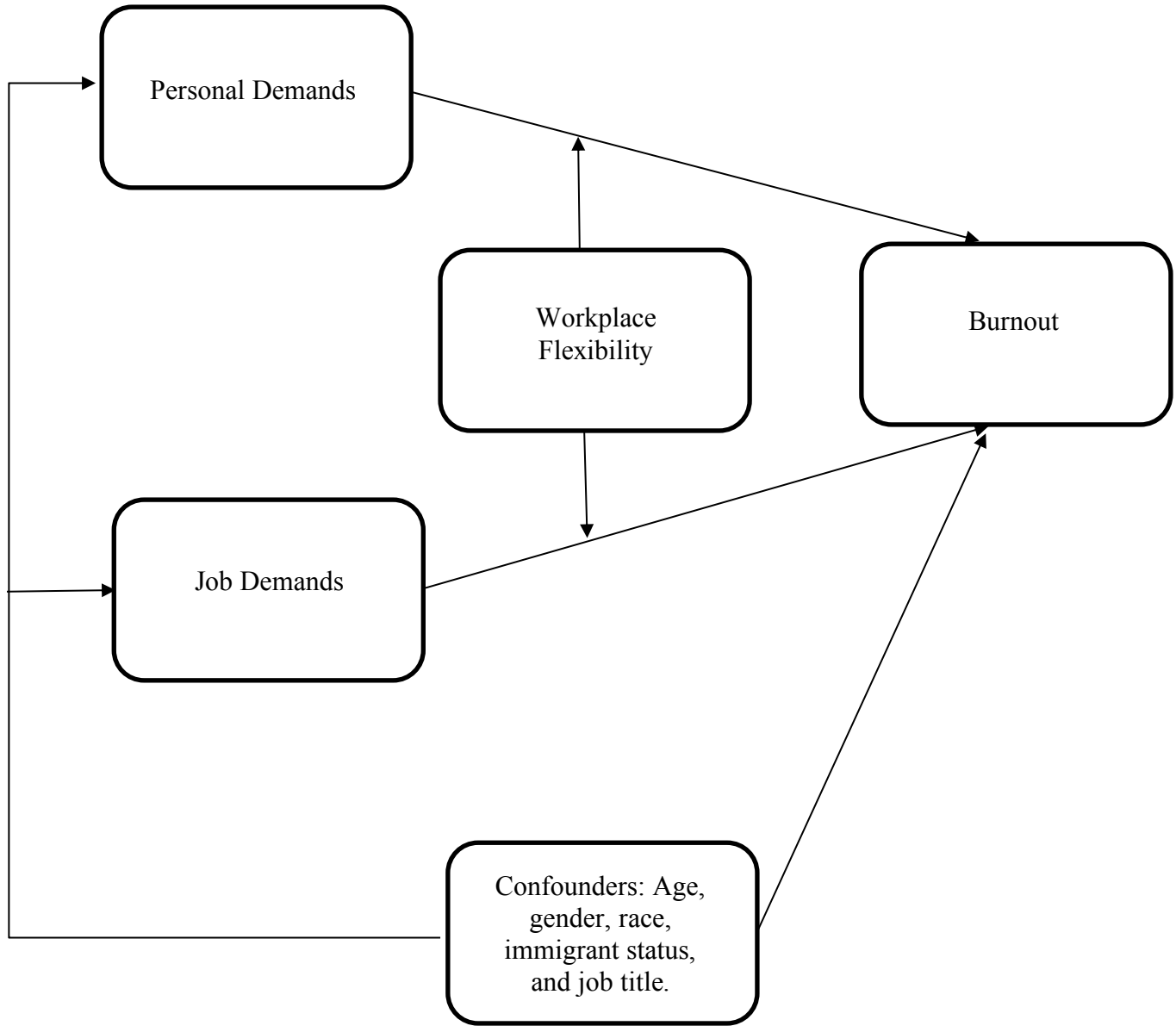

Figure 2. Path Diagram of Personal and Job Demands on Burnout and Buffering Effect of Workplace Flexibility.

Results

Of the 874 healthcare workers in the sample, 92.91% are womxn, 85.24% are nurses, 82.15% identified as white, 84.10% are born in the U.S., and 29.18% are within the ages of 30-39 years old.

Table 1. Demographic characteristics of sample. (N=874) [SD=standard deviation].

	Observations (%) or Mean ± SD	Observations of Burnout Cases (%) or Mean ± SD	p[a]
Burnout			
No	628 (71.85%)		
Yes	246 (28.15%)		
Family Status			.180
Single no child	232 (26.54%)	70 (28.46%)	
Single with child	45 (5.15%)	12 (4.88%)	
Married no child	323 (39.96%)	100 (40.65%)	
Married with child	274 (31.35%)	64 (26.02%)	
Job Strain			<.001
Low Strain	179 (20.48%)	17 (6.91%)	
Passive	234 (26.77%)	35 (14.23%)	
Active	210 (24.03%)	69 (28.05%)	
High Strain	251 (28.72%)	125 (50.81%)	
Workplace Flexibility (1-5; higher=better)	1.54 ± .24	1.48 ± .23	<.001
Age			.210
<30	250 (28.60%)	81 (32.93%)	
30-39	255 (29.18%)	73 (29.67%)	
40-49	158 (18.08%)	42 (17.07%)	
50+	211 (24.14%)	50 (20.33%)	
Gender			.473
Men	62 (7.09%)	15 (6.10%)	
Womxn	812 (92.91%)	231 (93.90%)	
Race			.126
White	718 (82.15%)	195 (79.27%)	
Black	79 (9.04%)	23 (9.35%)	
Latinx	35 (4.00%)	16 (6.50%)	
Other	42 (4.81%)	12 (4.88%)	
Immigrant Status			.396
U.S. Born	735 (84.10%)	211 (85.77%)	
Non-U.S. Born	139 (15.90%)	35 (14.23%)	
Job Title			.362
Nurse	745 (85.24%)	203 (82.52%)	
PCA	92 (10.53%)	31 (12.60%)	
Other	37 (4.23%)	12 (4.88%)	

a. p-values of Chi-square for categorical variables and t-tests for continuous variables

Almost 40% are married with no children. Twenty-nine percent of the healthcare workers are high strained which means that they experience high demands and low control at work. For workplace flexibility, on a scale of 1 (Very Little) to 5 (Very Much), the mean was 1.54 (SD=.24) meaning that when averaging across all items, higher scores corresponded to higher perception of workplace flexibility.

Of the total sample, 28.15% of the healthcare workers experienced burnout. Close to 41% are married without children and 51% of high strained healthcare workers reported burnout. Among those who are burned-out the mean of their perceived workplace flexibility is 1.48 (SD=± .23). In examining the distribution of burnout within our covariates 33% of individuals less than 30 years old, 94% of womxn, 79% of white, 86% of U.S. born, and 83% of nurses reported burnout (Table 1).

Given that healthcare workers who are married without children are our largest cohort in the sample, we conducted a separate analysis of the descriptive characteristics of the group (Appendix G). About 69% reported burnout and 31% are high strained workers. On average about 1.54 (SD=.24) reported perceived workplace flexibility. Close to a third (35%) of married without children are less than 30 years old, 91% are womxn, 88% are white, 89% are born in the U.S. and 90% are nurses.

In our first model (Model 1), we tested the associations of different family structures and burnout. None of the family structures were significantly associated with burnout. In the following model (Model 2) we adjusted for job demands, compared to low strained healthcare workers, active (OR=4.58; 95% CI=2.59,8.13) and high strained (OR=9.43; 95% CI=6.15,14.45) healthcare workers were all significantly associated with higher odds of burnout.

In model 3 we adjusted for workplace flexibility (OR=.36;95% CI=.17,.76) and it was significantly associated with lower odds of burnout. Workplace flexibility also partially attenuated the associations of active (OR=4.58;95% CI=2.35,7.66) and high strain (OR=8.11;95% CI=5.14,12.79) and odds of burnout among healthcare workers.

Table 2. Logistic regression modeling of relationship of personal and job demand on burnout. [OR=odds ratio; 95% CI= 95% confidence interval.]

	Model 1 OR (95% CI)	Model 2 OR (95% CI)	Model 3 OR (95% CI)	Model 4 OR (95% CI)
Family Status (ref Single no child)				
Single with child	.84(.45,1.56)	.84(.44,1.60)	.87(.46,1.65)	.75(.38,1.47)
Married no child	1.04(.69,1.55)	.98(.63,1.52)	.99(.63,1.56)	1.08(.66,1.75)
Married with child	.71(.46,1.07)	.73(.47,1.13)	.73(.47,1.14)	.71(.43,1.16)
Job Strain (ref Low Strain)				
Passive		1.70(.89,3.23)	1.60(.83,3.06)	1.34(.68,2.63)
Active		4.58(2.59,8.13)***	4.24(2.35,7.66)***	4.33(2.38,7.89)***
High Strain		9.43(6.15,14.45)***	8.11(5.14,12.79)***	7.72(4.88,12.21)***
Workplace Flexibility (1-5; higher=better)			.36(.17,.76)**	.29(.13,.61)***
Age (ref <30)				
30-39				.95(.61,1.47)
40-49				.91(.52,1.57)
50+				.71(.45,1.12)
Gender (ref Men)				
Womxn				1.27(.61,2.66)
Race (ref White)				
Black				1.56(.86,2.85)
Latinx				2.39(1.07,5.34)*
Other				1.06(.50,2.22)
Immigrant Status (ref U.S. Born)				
Non-U.S. Born				.76(.42,1.37)

Job Title (ref Nurse)	
PCA	2.16(1.14,4.10)*
Other	1.64(.61,4.42)

*p < .05, **p < .01, ***p < .001

In the final model where we adjusted for covariates (age, gender, race, immigrant status, and job title), there were no associations between family status and odds of burnout. Several of the categories of job strain were associated with odds of burnout: active (OR=4.33; 95% CI=2.38,7.89) and high strain (OR=7.72, 95% CI=4.88,12.21). The odds of burnout among active and high strained healthcare workers were also attenuated, meaning that the odds of burnout for active healthcare workers decreased by 5% and 18% for high strained workers. The calculation for attenuation is achieved by subtracting the odds ratio of the original main effect of the variable from the adjusted odds ratio and dividing the total sum from the odds ratio of the original main effect. Workplace flexibility (OR=.29; 95% CI=.13,.61) remained statistically significant and associated with lower odds of burnout.

Table 3. Interaction terms between personal and job demands and workplace flexibility on burnout [OR=odds ratio; 95% CI= 95% confidence interval.]

	OR (95% CI)
Family Status	
Single with child	.85 (.41,1.76)
Married no child	1.12 (.73,1.71)
Married with child	.74 (.48,1.13)
Workplace Flexibility	.07 (.02,.24)***
Interaction terms	
Single with child x Workplace Flexibility	.19 (.01,5.53)
Married no child x Workplace Flexibility	6.02 (1.06,34.08)*
Married with child x Workplace Flexibility	3.26 (.52,20.60)
Job Strain	
Passive	1.73 (.89,3.37)
Active	4.66 (2.45,8.86)***
High Strain	8.67 (5.33,14.08)***
Workplace Flexibility	1.33 (.19,9.48)
Passive x Workplace Flexibility	.58 (.05,7.37)

Active x Workplace Flexibility	.14 (.01,1.48)
High Strain x Workplace Flexibility	.19 (.02,1.60)

We then incorporated interaction terms to determine the moderating effect between workplace flexibility and family status and job strain. Results of the two-way interaction between family status and workplace flexibility (OR=6.02; 95% CI =1.06,34.08; p<.05) suggest that higher perception of workplace flexibility intensified the association of married healthcare workers without children and burnout. The increased odds of burnout indicated in the interaction term between workplace flexibility and married without children can be further explained by high strain (40%) being the largest frequency of reported job strain among married healthcare workers without children (Appendix H).

To further understand the moderating, or buffering, effect of workplace flexibility on burnout by job and personal demands, we stratified the sample between healthcare workers with perceived low versus high workplace flexibility (Table 4). Married healthcare workers without children with perceived high workplace flexibility (OR=1.79; 95% CI=1.01, 3.18) are associated with higher odds of burnout compared to married healthcare workers without children (OR=.69; 95% CI=.41,1.17) with low perceived workplace flexibility. Active (OR=10.25; 95% CI=3.27,32.12) and high strained (OR=17.49; 95% CI=6.50;47.04) healthcare workers with perceived low workplace flexibility are associated with higher odds of burnout than active (OR=2.62; 95% CI=1.28,5.37) and high strained (OR=5.94: 95% CI=3.24,10.89) healthcare workers with perceived high workplace flexibility.

Table 4. Relationship of burnout and job and personal demands by low and high workplace flexibility. [OR=odds ratio; 95% CI= 95% confidence interval.]

	Low Workplace Flexibility OR (95% CI) n=439	High Workplace Flexibility OR (95% CI) n=435
Family Status (ref Single no child)		
Single with child	.83 (.31,2.21)	1.17 (.50,2.71)

Married no child	.69 (.41,1.17)	1.79 (1.01,3.18)*
Married with child	.55 (.31,.99)*	1.00 (.56,1.80)
Job Strain (ref Low Strain)		
Passive	2.91 (.84,10.10)	1.27 (.56,2.91)
Active	10.25 (3.27,32.12)***	2.62 (1.28,5.37)**
High Strain	17.49 (6.50,47.04)***	5.94 (3.24,10.89)***

Figure 3. Relationship of burnout and personal demands by low and high workplace flexibility. Reference group is single no child.

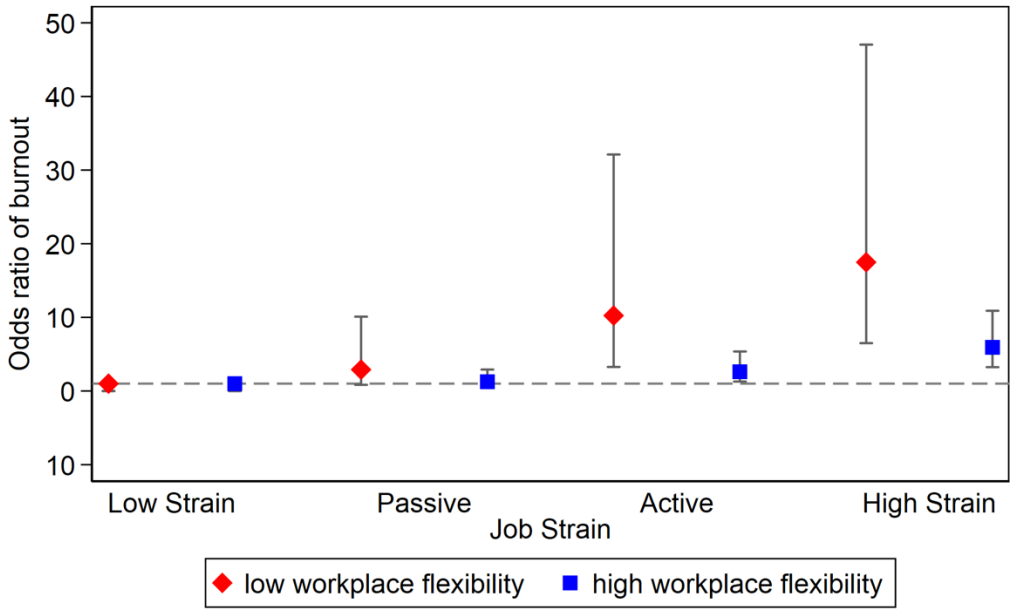

Figure 4. Relationship of burnout and job demands by low and high workplace flexibility. Reference group is low strain.

Discussion

The purpose of the present study is twofold: first it examined the associations of job and personal demands and workplace flexibility on burnout, and second it tested the moderating effect of workplace flexibility and job and personal demands on burnout. We found that childless married healthcare workers and those who were categorized as active and high strained are more likely to experience burnout. Workplace flexibility slightly attenuated the odds of burnout among active and high-strained healthcare workers and it moderated burnout among childless married healthcare workers.

Healthcare workers with perceived low workplace flexibility are associated with higher odds of burnout. In our stratified sample of perceived low versus high workplace flexibility, active and high strained healthcare workers in the low workplace flexibility sample, were

associated with higher odds of burnout. High strained jobs pertain to work where workers are expected to perform demanding tasks with little control in various aspects of the job such as how to execute their job, pace of work, and scheduling of deadlines while active workers experience high demands in the workplace but have control in facets of their job which lowers the likelihood of burnout and increases motivation among workers (Kain & Jex, 2010). Having perceived low workplace flexibility can heighten job strain. For instance, because healthcare workers provide 24/7 care, some healthcare workers with demanding responsibilities at work may have little control when they are scheduled to work (Bullock & Waugh, 2004) which can pose as a challenge in balancing personal and job demands due to inconsistencies in scheduling that can contribute to burnout. Within the framework of SDT (Sidanius et al., 2004; Sidanius & Pratto, 2012), not all healthcare workers have the same proportion of job demand and decision latitude because of inequities in the workplace (Kossek & Lautsch, 2017) which suggest that some workers may not fully benefit from organizational policies. While the interaction term was not statistically significant between the relationship of job strain and burnout, stratified models showed that the association between job strain and burnout was qualitatively different for those with high and low workplace flexibility. This suggests there are different ways of understanding the moderating effect of workplace flexibility on job strain and burnout than interaction terms alone. Moreover, workplace flexibility is not necessarily a quality of the worker but rather a product of the working environment.

Workplace flexibility moderated burnout among married healthcare workers without children. This is somewhat inconsistent with existing findings that found that workplace flexibility is beneficial for single parents and workers with heavier familial responsibilities (Jeffrey Hill, Jacob, et al., 2008; Jung Jang et al., 2012). Married healthcare workers without

children (OR= 1.08; 95% CI:.66,1.75) did report the highest rate of burnout in our sample (40.65%) as well as higher odds of burnout compared to single healthcare workers. This group may be experiencing work-family backlash (Young, 1999) that can create the expectation among married healthcare workers to be more flexible and take on heavier workloads than their counterparts with children. For instance, the largest cohort of married healthcare workers without children are under 30 years old (35%) and may be assumed to take on more inconsistent shift schedules. Within and across familial structures, this group also had the largest proportion of high strained workers (31%). They may also experience other stressors at home that are unrelated to stressors that single and married parents may have perhaps related to financial, communication, or satisfaction issues.

The lower distribution and lower odds of burnout among single and married parents compared to childless married healthcare workers also imply that having children is perhaps a protective factor from burnout. A work-family balance approach perhaps is a more useful indicator that increases job and family satisfaction which can decrease or prevent burnout (Wayne et al., 2017). Furthermore, another study also suggest that considering the quality of relationship as opposed to just the familial structure may provide a better explanation of understanding stressors in families (Hannighofer et al., 2017). Using the framework of the JD-R model (Demerouti et al., 2001), our findings show that considering personal demands as an additional construct to the model is imperative in understanding burnout and how job resources such as workplace flexibility can possibly influence the likelihood of burnout when both job and personal demands are accounted for.

Secondary findings show that workplace flexibility is associated with lower odds of burnout among healthcare workers. This study builds on previous studies that found workplace

flexibility has numerous benefits to healthcare workers including associations with higher likelihood of preventive care use (Sabbath, Sparer, et al., 2018) and physical activity (Nelson et al., 2014). Aspects of workplace flexibility can potentially explain the lowered odds of burnout for workers. For instance, allowing for more flexible scheduling arrangement (Grzywacz et al., 2008) and providing time off (Kühnel & Sonnentag, 2011) have been associated with lower odds of burnout among workers.

Certain groups in the sample also had higher odds of burnout. Compared to nurses, PCAs (OR=2.16; 95% CI: 1.14,4.10) were at higher-risk for burnout. In addition, compared to white healthcare workers, Latinx healthcare workers (OR=2.39; 95% CI: 1.07,5.34) also have significant odds of burnout. Such disparities may be explained by the intersecting identities (gender, race, sexual orientation, etc.) (Kossek & Lautsch, 2017) of healthcare workers that places them at higher risk for discrimination which contribute to feelings of burnout (Volpone & Avery, 2013). Healthcare organizations should consider evaluating and modifying organizational practices to ensure that their healthcare workers are benefitting equally. This may prove beneficial especially to high strained workers and PCAs who are not only dealing with performing demanding tasks with little control but the demands of familial life that can contribute to increased likelihood of burnout. Patient care associates are particularly of interest as targets for intervention for healthcare administrators due to their low wages that often leads many low-wage workers to work double jobs or pick up overtime shifts (Devine et al., 2006; Wharton, 2006) that can be associated with burnout.

Strengths and Limitations

Our study has limitations. The study used a single-item measure of burnout which can pose as a problem because it may only examine a specific aspect of burnout. While the measure

of burnout used for this study has been validated by previous studies showing that a single-item question derived from Maslach's Burnout Inventory Scale is a reliable measure, the question specifically asked in this study pertained to emotional exhaustion which excluded the construct of depersonalization (West et al., 2012). The 55% response rate of the respondents is low and may pose as a limitation in regards to reflecting the demographics of the workers in the setting of the study. An earlier wave of BHWHS where data was collected between 2008-2009 had a 79% response rate (Sabbath et al., 2014). Nevertheless, examining the demographics of the study mirrors the general characteristics of the workforce in hospitals among nurses and PCAs that are predominantly womxn, white, and have more nurses than PCAs per unit. Another potential limitation of the study is that it did not account for the differences in patient load per worker. As discussed in the introduction section, nurses on average are in charge of 5-6 patients while there are only 2 PCAs per unit that provide physically demanding services of 20 to 40 patients in the unit.

Certain familial structures may not be fully represented in our data, specifically parents whose offspring are not living with them. The study asked respondents, "how many children under and over the age of 5 live in your home 3 or more days per week?" Thus, we may not be able to capture respondents who have children who don't live with their children at all or intermittently. Parents not living with their children may be a result of numerous reasons such as divorce which has been associated with burnout (Hald et al., 2020). However, co-parenting has been associated with lower likelihood of burnout (Mikolajczak et al., 2018). Furthermore, single parents or married workers who may have children from previous marriages are potentially experiencing additional personal demands that we are not able to distinguish. The study also did not consider additional caregiving responsibilities where respondents may be providing

caregiving responsibilities to another family member such as an older adult parent that may contribute to their personal demands. Lastly, our findings may not be generalizable beyond healthcare workers who work in hospital settings.

A strength of our study is that it includes a broader sample of healthcare workers in understanding the associations of burnout and job and personal demands as well as the moderating effect of workplace flexibility compared to previous studies on burnout that examined healthcare workers independently (Leineweber et al., 2014; Wang et al., 2012). In addition, our study also showed that the JD-R model should consider including the construct of personal demands in understanding the broader influence of job resources on the experiences of healthcare workers. Scholars have proposed personal resources to moderate job demands, instead, the study found that personal resources mediated job resources and workplace engagement (Xanthopoulou et al., 2007). Our study builds on the potential expansion of the model to not only consider personal resources but also how job resources can moderate personal demands. Finally, our framing of job and personal demands allowed a more in-depth understanding of the topic. Following the Job Demands-Control model (Karasek, 1979) to construct the characterization of job demands is helpful in reflecting the complex conditions in which healthcare workers operate in healthcare settings. In addition, the additive approach to familial demands of relationship status and number of children, as opposed to testing for these variables separately, is able to capture a more accurate understanding of familial structures at home that may cause pressure or facilitation.

Conclusion

This study suggests that workplace flexibility may have an influence in mitigating the negative effects of burnout among healthcare workers who are experiencing high demand and

low control in the workplace. Stratified samples showed that high strained healthcare workers with perceived low workplace flexibility is associated with higher odds of burnout. In addition, workplace flexibility moderated the relationship between childless married healthcare workers and likelihood of burnout compared to other familial structures.

Implications for this study denote that while larger structural changes in the workplace may take time and can be costly to lessen poor health outcomes such as burnout among healthcare workers, healthcare administrators can mitigate burnout by improving the efficacy and accessibility of workplace flexibility. This can include incorporating flexibility into jobs when possible even when a full job redesign to reduce job strain is unfeasible among high strained workers. Implementing equitable workplace flexibility policies that regulates workplace flexibility in accordance with the worker's demands in their job and personal spheres can possibly lower burnout which can reduce healthcare expenditures, improve the health and well-being of workers, and secure the quality of care that patients receive.

Chapter V. Job and Personal Resources of Filipina Care Workers in New England

Introduction

Care workers in the informal sector are a vulnerable population to violence, hazards, and abuse (Chang, 2016). Informal sectors pertain to occupational sites where there is inadequate to non-existing rights protecting workers (Indon, 2002; Vogel, 2006). Currently, there are about 2.5 million care workers in the informal sector in the U.S. (Calfas, 2019). Care workers are primarily composed of womxn (95%), racial or ethnic minorities (54%), and immigrants (46%) (Burnham & Theodore, 2012). Between 2016 through 2026, there is an expected job increase for home health aides (41%) (Bureau of Labor Statistics U.S. Department of Labor, n.d.-b) and childcare workers (7%) (Bureau of Labor Statistics U.S. Department of Labor, n.d.-a). Thus, it is crucial to examine the demands experienced by care workers and identify resources available to them that can buffer poor working experiences and their well-being.

Conceptualizing Care Work and Care Workers in the Informal Sector

Care workers deliver in person services that develop the care recipient's human capabilities such as their physical, mental, and emotional skills (England et al., 2002). While some care workers are hired for specific duties that include taking care of their employer and the employer's family members, bathing, cooking, procuring groceries, doing laundry, and cleaning – to name a few, others perform multiple tasks beyond their agreed responsibilities after they began working (Nazareno et al., 2014; Parreñas, 2000, 2001b). Types of care workers in the informal sector range from domestic workers, babysitters, home health or personal aides, au pairs, caregivers, housecleaners, etc. (Applebaum, 2010). This paper defines the informal sector as locales in which services are distributed by self-employed or independent workers (Indon,

2002). It is referred to as an informal sector due to the limited or shortage of policies and benefits that provide protection to workers (Indon, 2002; Vogel, 2006).

Care workers are hired through word-of-mouth, agencies, and advertisements posted online and in-print (Hondagneu-Sotelo, 2007). Some care workers are hired from other countries specifically from the global south. Prospective foreign care workers enter the U.S. through three types of U.S. visas that employers can sponsor their care worker for: A-3, G-5, and B-1. The A-3 visa is for care workers who work for government ambassadors and consulates, G-5 visa is for employees of international organizations, and B-1 visa is for workers who are accompanying U.S. citizens or individuals with nonimmigrant status to the U.S. (Romero, 2003; Zarembka, 2002). It is also possible that some foreign workers enter the U.S. with a tourist visa and overstay the time allotted for them to remain in the country, effectively making them undocumented (Flores, 2010).

Care workers are paid in numerous forms. Some are hired as an employee using a W-2 tax form, independent contractors using a 1099 tax form, or under-the-table that is not reported to the government; the foremost allows employers to contribute to the employee's Social Security and other benefits while the other two options have limited to no benefits (Nazareno et al., 2014). A survey of domestic workers from 14 U.S. cities reported their median hourly wage is $10 with about 23% of the respondents paid below minimum wage (Theodore et al., 2018). Moreover, about 56% worked overtime and were paid a flat rate. With little pay and benefits, care workers may undertake a second occupation doing similar duties while some engage in precarious jobs working as sex workers (Hall et al., 2019).

Job and Personal Demands Among Care Workers

Job Hazard. The multitude of job duties that care workers execute places them at at-risk for negative health outcomes. Hazards like the cleaning supplies that care workers use expose them to toxic chemicals that have been associated with skin irritation and respiratory difficulty (Theodore et al., 2018). Care workers move and lift heavy objects and are in uncomfortable positions for lengthy periods of time when cleaning or providing care to recipients that have been associated with musculoskeletal injuries and at-risk for other physical injuries. Medical procedures are increasingly being implemented at home by care workers who are certified to perform these procedures or are self-administered by care recipients themselves that places care workers at-risk to exposure to sharp objects and other blood and body fluids; one study found that annual sharp injuries incidence rates of 5.1 per 100 full-time equivalent (FTE) and 1.0 per 100 FTE among home nurses and health aides respectively (Quinn et al., 2009).

Job Stressors. Interpersonal stressors between employers and care workers also exist. Care workers may experience physical and verbal abuse from care recipients or the recipient's family members (Quinn et al., 2016) that can influence psychological distress. Care workers who have developed close and intimate relationships with their employers may experience grieving when their employer passes away (Markkanen et al., 2007) that has been associated with depression among care workers (Chan et al., 2013). Some care workers also live with their employers which entail some form of 24/7 care. Live-in care workers reported poor sleep quality due to persistent interruption of their sleep in order to perform certain tasks such as administering medication to care recipients at irregular hours that can affect their sleep quality (Burnham & Theodore, 2012; Nazareno et al., 2014).

Particular groups among care workers are even more vulnerable due to their precarious immigration status. Undocumented care workers are afraid to report experiences of abuse and

harassment in the workplace because of fear of retaliation or threat of deportation from their employers (Kristen et al., 2015). The composite outcome of such poor working conditions and experiences may be stress, burnout, suicide ideation, and misuse of substances (e.g. drinking, smoking) in this population (Hall et al., 2019).

Personal Demands. Care workers, particularly immigrant care workers, also experience personal demands and experiences related to being an immigrant that can affect their functionality and overall well-being. Among immigrant care workers, the stress of migrating to another country and acculturating to their host society can be stressful. The stress of migration among recently immigrated Filipina domestic workers in China were associated with symptoms of anxiety, depression, somatization, and post-traumatic stress disorder (Mendoza et al., 2017). Gendered roles performed by womxn also have compounding effects for care workers. Womxn are often held accountable to double day jobs or a second shift which entails providing care not just to their employers but also to their family once they return home that can increase risk physical and mental stress (Blair-Loy et al., 2015; Boris & Fish, 2014; Hochschild & Machung, 2012). The notion of home, within the context of immigrant care workers can be interpreted broadly because of globalization that situates and defines home in other means. Care workers who work in other countries reified the creation of transnational families that expanded the transmission of care through letters, phone, and technology such as social media platforms (e.g. Facebook messenger, Skype) (Francisco-Menchavez, 2018a). The gendered aspect of care work ushered scholars to conceptualize transnational mothering as a concept that disrupts the ideology of the Filipina/o family that places the labor of reproduction and production on womxn, as mothers, working in other countries (Parreñas, 2001a). The cost of isolation, and for some, physical separation from family members and friends, engender an emotional toll for care

workers. The chronic stress of worrying about family members back in their countries of origin have been associated with clinical depression among domestic workers (Bagley et al., 1997). In fact, countries like Kuwait designated hospital wards to domestic workers with spinal cord injuries attempting to escape or attempting suicide because of depression (Varia, 2012). This suggests that the amalgamation of work and personal stressors among care workers are associated with poor mental health.

Personal and Job Resources Among Care Workers

Personal Resources. While some care workers may have unpleasant experiences, resources and support also exist. A common source of support among care workers are their family members and friends whom they seek emotional and mental health solace from, vice versa (Francisco-Menchavez, 2018a). Certainly, studies found personal incentives beneficial to family members a form of motivation and coping for care workers like financing their children's education (Francisco-Menchavez, 2018b). Others are encouraged by funding their retirement or providing a path for their family members to migrate to take advantage of the opportunities in the country where they work (Salami et al., 2014). Countries like Canada implemented pathways to permanent residency for care workers through the Caregiver Program if they work for an employer for two continuous years which grants workers to subsequently petition for their family members to migrate (Ferrer, 2017; Parreñas, 2017). While previous studies found positive mental health benefits of social support and networks (Kawachi & Berkman, 2001; van der Ham et al., 2015), social support from family and friends can also potentially negatively influence the mental health of care workers specifically among womxn who may emotionally carry the burden of their social networks (Mendoza et al., 2017). Others have also found religiosity and spirituality as a form of resource and coping. Studies have shown that care workers who attend

religious services and are involved with their church organization have been associated with lower stress levels (van der Ham et al., 2014). Because care workers operate in private homes, the development of meaningful relationships of care workers with their employers and their employer's family members overtime can engender a supportive working environment (Ferrer, 2017).

Job Resources. Legal policies also exist for care workers. Historically, several landmark policies in the U.S. discounted care workers in the informal sector. When the New Deal was established in the 1930s, the Social Security Act of 1935 excluded domestic workers and agricultural farmworkers from receiving benefits, arguably because of racial discrimination since these sectors were predominantly comprised of African Americans (DeWitt, 2010). During the passing of Title VII of the Civil Rights Act of 1964, which forbids harassment and discrimination in the workplace, excepted businesses with fewer than 15 employees which did not protect domestic workers often working as single employees (Fretto, 2011). The establishment of the Occupational Health and Safety Act of 1970, the National Labor Relations Act, and the Fair Labor Standards Act also exempted employers from adhering to safety and health standards to protect the well-being of care workers (Castro, 2008).

Because of organizing led by care workers and other proponents, New York became the first state to implement a Domestic Workers' Bill of Rights on November 29, 2010 (Applebaum, 2010). The law mandated several provisions: the establishment of an 8-hour workday and decrees for overtime work and pay considered after 40 hours of work for those who live-out and 44 hours for live-in care workers, requirement of one day off a week, three paid days off during the year if the employee has worked for the employer for more than a year, protection from discrimination and harassment, and temporary disability status regardless of working status

(Applebaum, 2010). Ten states (California, Connecticut, Hawaii, Illinois, Massachusetts, Nevada, New Mexico, New York, Oregon, and Philadelphia) and the city of Seattle have since passed iterations of the bill (Abello, 2019). On July 15, 2019, Senator Kamala D. Harris and U.S. Representative Pramila Jayapal introduced the federal version of the Domestic Workers Bill of Rights Act and has since been referred to a committee for review (U.S. Senator for California Kamala D. Harris, 2019). A health assessment of Massachusetts's Domestic Workers' Bill of Rights predict that the provisions associated with the bill will decrease stress, harassment, and poor sleep based on existing literature (Auerbach et al., 2014). Whereas care workers constitute and are represented by numerous racial and ethnic groups, one of the most prominent group of care workers in the U.S. are Filipina/os due to an enduring history of Philippine-U.S. relations.

The Current Study: Filipina/os in New England

The aftermath of the Philippine-American War of 1902 made the Philippines a U.S. colony until the country gained its independence from the U.S. in 1946 (Choy, 2003). Under U.S. rule, Filipina/os entered the country as nationals and *pensionados* (Teodoro, 1999). After independence, the quota for Filipina/os allowed to enter the U.S. annually was reduced to 50 (G. E. Wheeler, 1964). It was not until the passing of the Immigration and Naturalization Act of 1965 when Filipina/os began migrating in multitudes again through the stipulations of family reunification and need for skilled and other skilled workers (Kennedy, 1966). Whereas these events and policies elucidate the migration of Filipina/os to the U.S., the Philippines also established its own state-sponsored policies that institutionalized the exportation of its citizens to the world and propagated what scholars argue as a collaborative empire between Western countries and the Philippines (Francisco, 2009).

In the 1970s, the Philippine government began to establish itself as a broker to produce, distribute, and regulate its citizens as workers for exportation to the world (Rodriguez, 2010). Former President Ferdinand Marcos issued Presidential Decree 442 in 1974, founding several government agencies that were later combined to launch the Philippine Overseas Employment Administration (POEA) in 1983. The purpose of the POEA was to streamline the hiring of Overseas Filipino Workers (OFW) in foreign countries. In addition, the POEA also worked with foreign hiring companies by requiring these agencies to either receive permission from POEA to recruit workers or contract POEA to disseminate job postings through their department or other Philippine-based recruitment agencies (Goss & Lindquist, 1995). In 1983, Executive Order 857 was also initiated that mandated OFWs to send their remittances through the Philippine banking system, sanctioning the government to profit from remittances (Rodriguez, 2010). In eschewing the perception of the exploitation of its people, the Philippine government re-framed the characterization of OFWs by adopting a neoliberal ideology of a moral economy that rationalize labor export policies and programs as a form of nationalism and specifically for womxn, a responsibility of caring for the state (Francisco, 2009). Programs such as the Migrant Heroes Week established through the 1995 Republic Act 8042 aimed to celebrate and acknowledge the efforts made by OFWs in helping the country's economy thrive and serve as envoys to the world, depicting them as bagong bayani (new heroes) (Rodriguez, 2010). Focusing further on the corporeal commodification of Filipina womxn, former President Gloria Macapagal Arroyo launched the "Supermaid program" in 2006 to train Filipina womxn as domestic workers (Francisco, 2009).

The labor export policies and programs that the Philippines established in corroboration with foreign policies of enticing workers has led to the mass migration of Filipina/os out of the

country, largely comprised of womxn. By 2016, it was estimated that an average of 6,000 Filipina/os leave the country every day to work in foreign countries in the seafaring, hospitality, construction, and care industries (International Labour Organization, 2018). The Philippines has largely profited from the significant outflow of workers, from April through September of 2018, OFWs sent over 239.5 billion pesos in remittances (Perez, 2019) comprising 10.2% of the country's Gross Domestic Product (GDP) in 2018 (The World Bank, n.d.). Markedly, the Philippine economy is dependent on the remittances of OFWs.

Currently, there are over 4 million Filipina/os in the U.S. About 44% of its population are primarily constituted in California followed by Hawaii, Texas, New York, Illinois, and New Jersey (Zong & Batalova, 2018). Because of the informality of care work in the informal sector, there is no clear estimate of the number of Filipina/o Americans in the U.S. who are care workers. Using the 2008 U.S. Census, it is estimated that there are about 114,000 Filipina/o Americans in the U.S. who are domestic workers, though this approximation is believed to be under-reported (P. Chua, 2009). New England is an uncommon destination and place of residence for Filipina/os. Unlike its more established counterparts in other areas of the country with distinct Filipina/o enclaves in the city and suburbs, the Filipina/o community in New England is dispersed. However, the region has witnessed a changing demographic. A recent report on Asian Americans in the Greater Boston area showed that while the Asian American population has decreased in the city of Boston, there has been a significant increase in suburban populations; Quincy, for example, had a sizeable Filipina/o population of 2,227 in 2016 (Watanabe & Lo, 2019). A previous report indicated that there were about 10,577 Filipina/os living in Massachusetts in 2005 (Chu, 2007). New England hosting numerous universities, research centers, tech companies, and hospitals can elucidate the migration of Filipina/os in the

region sanctioned by the residues of the Immigration Act of 1965. Certainly, with the shortage of healthcare workers, states like Maine began recruiting Filipina/o nurses directly from the Philippines to migrate and fill the labor gap (Gooch, 2018). With the migration of professional Filipina/o workers to New England, the provision of being able to petition family members from the Philippines once petitioners are naturalized may explain the ingress of Filipina/o care workers in the informal sector as one of the pathways along with the other types of U.S. visas like the H2 visa for non-professional or other skilled workers (Francisco & Rodriguez, 2014). Globalization, labor demands, and the changing demographic of the U.S. indicate that New England may continue to observe a continuous growth of its Filipina/o population.

Current Study

Whereas most studies on Filipina care workers have been conducted in countries like Hong Kong (Constable, 2009), Canada (Ferrer, 2017), and Israel (Ayalon, 2009), and studies accomplished in the U.S. have focused on cities like Los Angeles (Nazareno et al., 2014) and New York (Francisco, 2009), this article extends previous literature by focusing on Filipina care workers in the New England region of the U.S. It also contributes to our understanding of the demands experienced by this workforce and resources available to them both in their working and personal spheres using the Job Demands-Resources (JD-R) model and cultural wealth perspective to frame these constructs which previous studies in this working population have not accomplished. The purpose of this study is to examine how Filipina care workers develop and access personal and job resources in the informal sector and in a geographic area where there is no prominent Filipina/o community. The paper is guided by the following research questions 1) What are the job and personal demands experienced by Filipina care workers? and 2) What are

the job and personal resources accessed by Filipina care workers? What are the barriers and facilitators to these resources?

This study can inform other studies on immigrant care workers in identifying factors that can potentially mitigate poor working conditions and their overall health. Moreover, it can also inform social workers and other proponents to advocate for policies in the U.S. and the Philippines to ensure that effective policies, programs, and services are available to Filipina immigrant care workers to safeguard their well-being and safety especially in areas of the U.S. where there are few Filipina/os.

Theoretical Frameworks

Job Demands-Resources (JD-R) Model

The JD-R model asserts that persistent intense job demands and scarcity of resources can cause strain and over exhaustion overtime leading to poor organizational and individual outcomes among workers (Bakker & Demerouti, 2007; Demerouti et al., 2001). However, if organizations integrated efficient job resources, instead, workers are then motivated which can benefit their well-being and the organization. Job demands denote chronic physical, psychological, and organizational efforts that have somatic, mental, and resource-related costs. Alternatively, job resources are physical, psychological, social, and organizational features that facilitate work tasks, mitigate stressors related to job demands, and encourage professional development among workers (Demerouti et al., 2001). Most studies that employ the JD-R model are conducted among formal sectors that have policies protecting the rights and well-being of workers (Vinod Nair et al., 2020). Studies in the informal sector where federal policies are nonexistent and state-level policies are limited using this model have yet to emerge. This study used the model to distinguish job demands and resources in the informal sector and extend the

model to also include personal demands and resources because of the known compounding and permeating effects of working and private spheres (Francisco-Menchavez, 2018b; Mendoza et al., 2017).

Cultural Wealth

The cultural wealth perspective is a strength-based approach contending that communities of color have existing assets entrenched within their culture and community that can thwart the insidious effects of systemic racism (Yosso, 2005). The perspective values the experiences and knowledge of communities of color that is disseminated within the community and intergenerationally. Such knowledge is reified in six forms of capital: aspirational, navigational, social, linguistic, familial, and resistant (Yosso, 2005). This perspective can be applied to Filipina workers who are working and residing in a predominantly white geographic location and a shortage of Filipina/o spaces and organizations. It is imperative to understand how Filipina/o care workers operationalize personal resources related to their culture that can potentially mitigate the effects of the demands of their job and private lives.

Critical Feminist Perspective

An occupation that is primarily gendered implores to be examined and analyzed with a critical feminist critique. Care work is gendered because of patriarchal and capitalistic ideologies that consigned womxn to the home and its associated duties (Gimenez, 2005). The conjecture that it is the innate role of womxn to perform these duties justified its unpaid provision. Instead, feminist scholars disputed that reproductive labor is a valid form of work and an essential facet of the industrial economy (Duffy, 2011). Moreover, in a racialized society, care work has sanctioned poor immigrant womxn of color to perform this task in the informal sector that

permitted white middle class womxn to take on leisure and professionalized careers (Chang, 2016; Glenn, 1992) further contributing to the racialization and classification of care work.

Method

Design

The present study followed a grounded theory research design framework (Chun Tie et al., 2019). This framework begins with purposive sampling, collection of data through methods appropriate for the purpose of the study (e.g. interviews, focus groups), and iterations of developing the data from codes, creation of categories, and analyzing the relationships of these categories to develop concepts, themes, and theories that answer the research question of the study. The process is further supported by constant comparative analysis and memoing throughout the process to find consistencies and inconsistencies and assist in tracking the process of theory development of the researchers involved (Chun Tie et al., 2019).

Participants

Following the framework discussed, the study implemented purposive sampling of Filipina care workers. Participants were recruited online through social media, non-profit organization listservs, physical flyers posted on community boards in cafes and parks, and word-of-mouth. Inclusion criteria for the study included 1) identifies as Filipina, 2) identifies as a womxn, 3) current or previous care worker in informal settings (e.g. home), 4) 18 years old and older, 5) an immigrant, and 6) currently resides in New England. Interested participants either emailed the researcher directly or called the provided Google voice number indicated on the recruitment materials. An initial phone screening was conducted with the researcher and prospective participant to assess if the participant met all inclusion criteria. Potential participants were also informed that the interviews can be conducted in both English and Tagalog for their

comfortability but no other Filipino languages (e.g. Kapampangan, Bisaya, Ilokano, etc.) due to the language fluency of the researcher conducting the interviews limited to only the two languages mentioned. Fourteen participants were recruited and interviewed for the study from May through July of 2019. Acknowledging the precarious nature of the working conditions and safety of home care workers, interviews were conducted where it was most convenient and comfortable for participants. Semi-structured interviews took place in person in cafes, non-profit organizations, their own homes, or homes of their employers. Thirteen participants were interviewed in person. One participant was interviewed over the phone. Two of the participants worked for the same employer and were interviewed at the same time. The use of joint or dyadic interviews for these two participants allowed for participants to co-produce knowledge together allowing for more robust data of their experiences at work (Polak & Green, 2015). To safeguard that one participant did not dominate over the other, the interviewer ensured that each participant was asked the same question after each participant responded and allowed for both participants to support or counter their co-interviewees responses. The interviewer made note of any non-verbal cues made by the participants during the duration of the interview in the interviewer's memo. Recruitment and interviews for the study were terminated after 14 interviews because there were little new information revealed by the respondents in several of the recent interviews conducted (Small, 2009).

Data Collection

A trained researcher fluent in English and Tagalog conducted the interviews in both languages. The researcher's native language is Tagalog and passed with high proficiency in an official university administered test in the Tagalog language. The researcher and participants oscillated in both languages during the entire interview, allowing both the researcher and

participant to express themselves in whichever language was most comfortable for them in various points of the interview. Participants were encouraged to speak in both languages because English is not the native language of the participants since being an immigrant is one of the inclusion criteria of the study. Thus, they may have difficulties discussing their experiences in the English language. In addition, cross-cultural studies have shown that participants speaking in their native language allows for richer data because there are certain words, expressions, metaphors, etc. that accurately depicts their experiences that the English language may not authentically convey (van Nes et al., 2010). Interviews were audio recorded using a voice recorder and lasted between 40 to 60 minutes. The interview prompts reflected constructs of the Job-Demands Resources Model (JD-R) (Bakker & Demerouti, 2007; Demerouti et al., 2001) and also included questions concerning personal demands and resources based on previous literature (Francisco-Menchavez, 2018b; Hall et al., 2019; Mendoza et al., 2017; Parreñas, 2001a). These questions examined job responsibilities, working conditions, access to resources and benefits (e.g. health insurance, paid sick leave, day off, etc.) and personal responsibilities (e.g. remittances, caretaking, transnational mothering, etc.). In addition, culture specific questions were adapted using the cultural wealth approach (Yosso, 2005). The questions asked pertained to access to Filipino food, entertainment, spaces, community, etc. See Appendix K for the interview guide. Because the study is conducted in both languages, the interview questions were translated and validated with a bilingual English and Tagalog speaker who is not involved with the study to ensure that the questions asked in the interviews depicted the objective of each question (Squires, 2009). Participants received a $50 gift card for participating in the study. The study is funded by the Center for Human Rights and International Justice at Boston College and approved by the Boston College Institutional Review Board (IRB).

Data Analysis

The interviews were transcribed and translated from Tagalog to English in a two-step process. First, the interviews were transcribed verbatim to how the interviews occurred where both researcher and participant spoke in both languages. The transcriptions were then de-identified (Stuckey, 2014). Then a trained researcher fluent in both languages translated the interviews entirely in English (Squires, 2009). A combination of grounded theory (Strauss & Corbin, 1997) and thematic analysis (Saldaña, 2009) was employed to analyze the data. The use of these two qualitative analytical methods have been used in other studies (Betancourt et al., 2013). Two trained researchers performed both open coding and a-priori codes related to the theories and concepts previously mentioned (JD-R model, personal demands and resources, and cultural wealth). These codes were developed to create the codebook. Because the study is using both thematic analysis and grounded theory, a priori-codes are appropriate in mirroring the constructs of the JD-R model whereas grounded theory allows for new data to emerge. Moreover, while some scholars might argue that a-priori codes are not reflective of grounded theory, others argued that the use of stepwise method that informs how the research is conducted is in fact a priori theory – a crucial claim of divergent grounded theory (Amsteus, 2014). The two coders independently coded 10% (n=2) of the same transcripts to determine trustworthiness. In instances where there were coding discrepancies, those issues were discussed and resolved between the two coders so that 100% agreement was reached. We then re-examined the list of codes to look for patterns and created categories and sub-categories. Through constant comparative analysis, we analyzed the relationships of the categories and sub-categories using coding methods such as axial, focused, and theoretical coding (Saldaña, 2009) to establish major categories which informed the construction of themes and/or concepts as appropriate. Themes

are subtle and implicit constructs and concepts shifts from general or real constructs to higher-level and abstract ideas (Saldaña, 2009). Atlas.ti 8.0 program was used for data analysis.

Statement of Positionality

Our positionalities as a cis-man Filipino immigrant and cis-womxn Filipina immigrant implores interrogation in our relationality to Filipina immigrant care workers in the informal sector. One of the researchers have parents who are both care workers who worked in the informal sector in the past and are currently working in the formal sector of the care industry. In addition, this researcher has been community organizing with low-wage workers who identify as Filipina/o and other race and ethnicities for several years which provides a complex duality in his understanding of the experiences of the population of the study that has allowed him to intimately interact and develop relationships while remaining to be a researcher with specific desires and objectives concerning the study. The other researcher has worked extensively with Filipina/o communities in health intervention and research. As Pillow (2003) highlights, in our practice of self-reflexivity as researchers, it is imperative to be cognizant of our positionalities in the entire process of conducting the study and analyzing the data to understand how our own positionalities and experiences have both contaminated the data with our familiarity of the population and the specific ethnic group but also as witnesses of being a non-care worker. This awareness informed how we assessed the data during the data analysis phase.

Results

Fourteen Filipina care workers participated in the study. Participants were assigned pseudonyms to protect their identity. Their ages ranged between 28 years old to 73 years old. The job titles reported by the participants are domestic workers, certified nursing assistant (CNA), nanny, caregiver, and child care provider. About 71% of the participants are full-time

care workers. Half of the participants lived in with their employers and half lived out while they were employed as care workers. The average years of U.S. residency among the participants is 16.19 years. Thirteen participants have a child and half are married. The themes that emerged from the data are categorized in five distinct categories: pull factors to New England, job stressors, job resources, personal demands, and personal resources (See Figure 5).

Table 1. Demographics of Filipina care workers in the study.

Name	**Age**	**Work Title**	**Residence**	**U.S. Residency**	**Children**	**Marital Status**
Melanie	38	Domestic worker	Live-out	2 years	1	Single
Geraldine	45	Nanny	Live-in	1 year	1	Divorced
Sheila	43	Nanny	Live-in	7 months	2	Married
Lydia	63	CNA & rents rooms	Live-out	33 years	1	Divorced
Eva	58	Part-time CNA & Bartender	Live-out	25 years	1	Single
Joy	49	Part-time CNA & full-time linen attendant in a hospital	Live-out	19 years	2	Married
Mirna	50	Part-time caregiver & bank teller	Live-out	21 years	3	Married
Belen	44	Part-time caregiver	Live-out	16 years	2	Married
Edna	73	CNA	Live-out	40 years	5	Married
Gretchen	43	Nanny	Live-in	5 years	2	Separated
Nida	55	Child care provider	Live-in	31 years	2	Married
Aurora	61	Domestic worker	Live-in	30 years	0	Widowed
Ligaya	42	Domestic worker	Live-in	2 years	3	Married
Aiza	28	Domestic worker	Live-in	1 year	2	Single

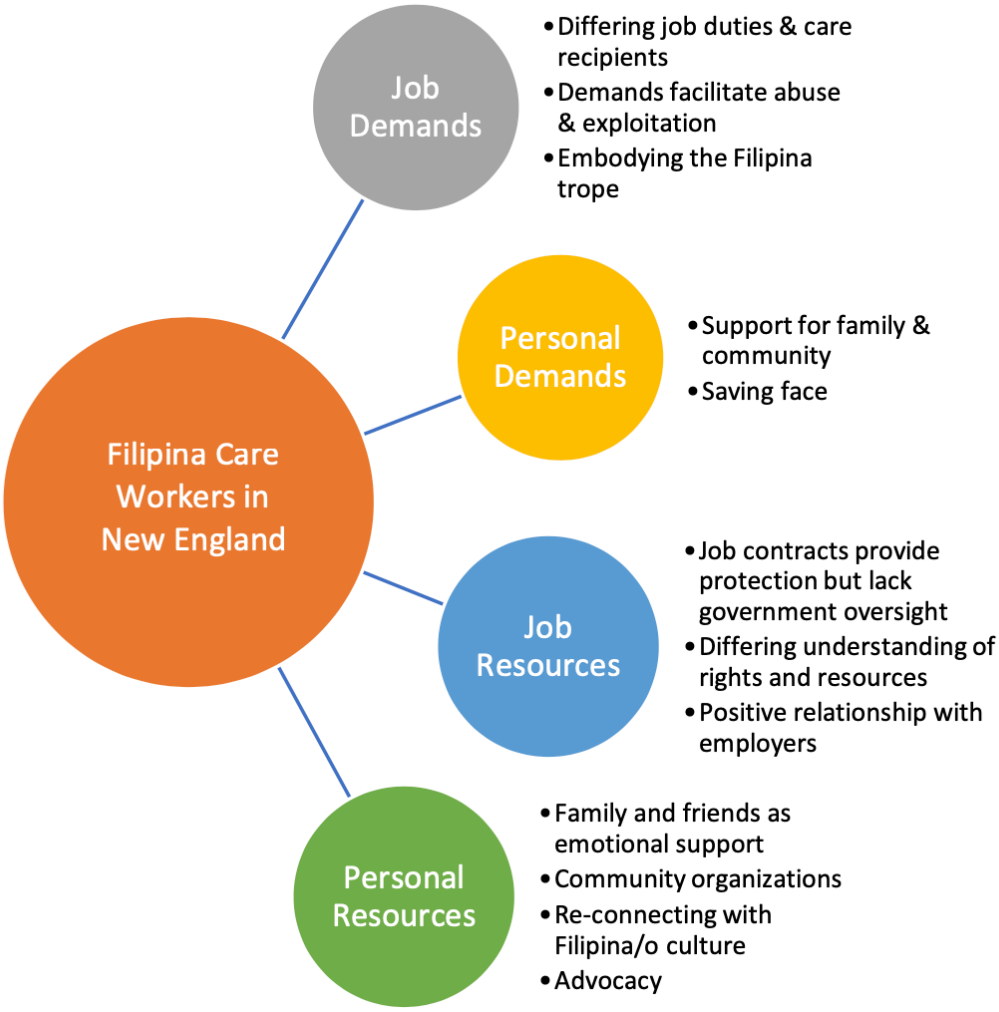

Figure 5. Thematic array of job and personal demands and resources of Filipina care workers in New England.

Pull Factors to New England

Family reunification. Respondents shared numerous reasons that led them to migrate to the U.S., specifically, the New England region. Over half of the respondents migrated as a result of family reunification policies. These respondents discussed that their family members who were already living and working in this region were able to petition them which in turn enabled them to petition their children, "I was petitioned by my mother. Then I was able to get my child to come to the U.S. when he was 4 years old" (Eva, 58 years old).

While some form of reunification transpired, some are further torn apart from their family by migration. For instance, Edna who has been living in the U.S. for 40 years moved because of her husband who was petitioned by his family. Because of family circumstances of some of her children, some were not able to migrate. In addition, as a result of restrictions and extended delay in petitioning family members, she was not able to petition her side of the family to the U.S. who have passed away over the years:

> I get homesick because of my children. And I think about being far away from my family. I'm the only one here while all of my husband's family is here. My father, mother, and siblings are all gone, I'm the only one left (Edna, 73 years old).

The institutions in New England are sites for services, training, & commerce.

Interestingly, over a quarter of the participants came to New England because of services or opportunities procured by their employers. Ligaya and Aiza who were both working as domestic workers for a family in the Middle East came to the U.S. because of prolonged health services needed by their employer's children, "Two of their kids, twins, they have special needs, they came here because they are getting treatment at a hospital" (Ligaya, 42 years old). It is important to note that both Ligaya and Aiza escaped from their employers and are considered legally as human trafficking survivors. Ligaya shared that she came to the U.S. with her employer's family a couple of years ago and came back because the children need to continue receiving treatment. Ligaya discussed that she was chosen to come because out of the three domestic workers who interviewed with the U.S. embassy, she was the only one able to procure a visa to come to the U.S.:

> I was the one that was able to pass the interview with the U.S. embassy that's why I was the one who was brought here to the U.S. The two other domestic workers I work with didn't pass their interviews. It was 2016 when I first came here. We stayed here for one year from 2016 to 2017. Then the second time we came in 2018, she [Aiza] came with us (Ligaya, 42 years old).

Aiza stated that coming to the U.S. was a relief for her because if she stayed in the Middle East, she would have been left with her employer's friends whom she said was more abusive than their employers:

> The truth is, when I found out that I'm coming, I was thinking that if I was left there in [Middle Eastern country], our employers would leave us with their friends who are worse. I was left at my employer's friend's house before and their children would spit at us and would kick us, and you can't do anything because they're kids. I figured that I would just come to the U.S. at least Ate Ligaya is here with me (Aiza, 28 years old).

While the procurement of extended health services is a prominent intention for employers, the opportunities for professional training in the region is also another motive. Geraldine was hired by her employers from another country to migrate with them to work as a nanny while they pursue fellowship programs in the health field:

> They're here to do their fellowship, so I came with them because I love children right? [laughs]. Yeah and I already have rapport with the child and even if I didn't want to go but thinking about the child suffering in a new country, in a new environment, it hurt my feelings, so why don't you just go with her? Because that's really the reason why you earn money right? (Geraldine, 45 years old).

Sheila and Gretchen, both also working in other countries, relocated to the New England region with their employers who are foreign government officials. They shared that their employer's jobs often require moving to another region or country every few years and they are given the option to join them or find new employers.

Job Demands

Differing job duties and care recipients enable work stress and injuries. Participants discussed a wide range of tasks as part of their job responsibilities. Some had multiple tasks from taking care of their employers and/or their children, cooking, cleaning, doing laundry, picking up and dropping off their employer's children from school, administering medicine, and bathing. Nida who is a child care provider takes care of 7 children, ranging from 3 years old to 5 years

old, in her own home during the weekday for 10 hours. She discussed the multiple duties she executes as a care provider, “I’m a nurse, I’m a cook, I’m a psychologist, I’m a therapist, I’m a teacher, everything that the child needs; I have to tend to all their developmental needs” (Nida, 55 years old). Nida stated that she doesn’t get any breaks at work even when the children are napping that by the end of the day she is spent, “…As soon as the kids left I just have no energy but that's because you know I've been doing this for so many years and I'm like "Oh the day is over, the same thing over and over again.” It is important to note that the job demands that Nida experienced may be different from other care workers in the study since power differentials exist because Nida is a business owner providing care in her own home. Thus, she may have more flexibility in controlling some aspects of her job duties while care workers who work in the home of their employers may not have similar latitude.

The number of tasks that some care workers have to perform increased their risk of injuries and illnesses. For instance, Melanie discussed an incident when she slipped on a toy and injured her toe that became sore which made it difficult for her to walk for several months but she was still expected to work. In addition, she also had an adverse reaction from cleaning products that made the sole of her feet burn and her hands red and itchy. She raised the issue to her employer to assist her in finding a doctor to examine her injuries:

> She told me she’d find a doctor but I waited a few months but I still was not seen by a doctor. Then she told me that health services are expensive in the U.S. Instead, she gave me Neosporin and Vaseline to use but my feet were still itchy and sore (Melanie, 38 years old).

Melanie did not know how to seek further help because she was unfamiliar with the area having recently immigrated, and often worked in isolation. She was not offered health insurance by her employer despite health insurance provided through her employers as one of the stipulations in obtaining her U.S. visa. Out of the 14 participants in the study, four (29%) did not

have health insurance. Akin to Ligaya and Aiza, Melanie also fled from her employers due to poor working conditions and is also a human trafficking survivor. They are now in the process of applying to change their immigration status in the U.S. but there has been a delay in receiving their working permits from the government, thus, they are relying on donations from organizations to pay for their rent and daily expenses.

On the other hand, some care workers perform specific job tasks that are restricted to taking care of the children or their elderly employer. Geraldine, 45 years old, delineated her daily routine with the child she is taking care of, "From morning to nap time, to cleaning toys, to washing her dishes, and food – preparation and all, except bathing because the parents want to do that." When asked about cleaning, cooking, or doing laundry for her employers she stated, "those are a bonus, if you want, [I] consider it as payback to the good things they have done for me… so why don't you just do a little kindness for the parents?" Geraldine deemed that since she doesn't have to pay for rent or utilities performing tasks beyond her duties is a small token of appreciation.

The demands of the job facilitate abuse and exploitation. Some of the expectations of the employers towards their care worker can be abusive and exploitative of the care worker. Melanie discussed how her employer and her employer's children would demand her to perform multiple tasks that has caused physical stress on her body:

> …It seems like they're trying to take advantage [of me]. Because in my job even if I'm already doing something they still ask me to do additional things even if they can do it themselves. For example, the 16 year old, I'm already doing something and she's just on the bed using her cellphone and she will still ask me to get her charger. When she takes a bath she would make me get her underwear and a towel even though she knows that I'm taking care of three other children… I'm always serving her…That's why I've been complaining that I'm having difficulty because my back and feet hurts. Even when I'm sick they force me to go out with them to push the child's wheelchair, even if it's raining… (Melanie, 38 years old.)

Other workers who live in with their employers are required to perform 24/7 care that affects their sleep quality. Ligaya and Aiza discussed that in addition to not being able to sleep properly because of anticipating the children they're taking care of waking up multiple times in the night, they also have to deal with unpleasant living conditions:

> Initially, we didn't have a place to sleep so we slept in the garage… and that garage is in front of a dump site. Later we moved apartments they made us sleep in the kitchen… we couldn't sleep well because if the children we are taking care of wakes up and they crawl and go down the stairs, we worry that they might fall (Ligaya, 42 years old).

The multitudes of demands expected of some of the care workers are abusive and despite these care workers advocating for themselves, they are met with false promises or are disregarded by their employers.

Embodying the Filipina trope as care providers. Care workers discussed that their employers preferred hiring Filipina care workers because of the reputation that Filipina care workers have been known for internationally. Scholars argued that Filipina care workers are perceived to have innate caregiving expertise – productive femininity – with an added export value (e.g. patience, dedication to their work, proficiency in English, etc.) through the marketing of Filipina womxn by the nation state as brokers to the global north (Guevarra, 2010). Sheila shared how her employers not only in the U.S. but her former employers in Egypt and Hong Kong where she also worked as a domestic helper shared similar sentiments about Filipina care workers:

> My male employer said that they preferred Filipinos instead of other ethnic groups because of how we take care of kids…Although illegal, in Egypt, employers will spend a lot of money so they can hire Filipinas…Even in Hong Kong, they like Filipinas because Filipinas already know how to speak English and they can teach their children English as well (Sheila, 43 years old).

Whereas employers hold these beliefs, Filipina care workers as well have internalized this trope where they equate being Filipino as being caring and hospitable because of the decades of policies enacted by the Philippine state to make Filipinas marketable to compete in the global market, etching its own niche in the industry of care work (Francisco, 2009; Guevarra, 2010; Rodriguez, 2008). Eva, 58 years old, who works as a bartender for a hotel and works part-time as a CNA doing graveyard shifts shared how it was her duty as a Filipina to do her job as a care worker well and remain awake overnight when she's taking care of her elderly patient, "You have to stay awake, especially us Filipinos, even if they're not our relative, we have to take care of them really well."

Personal Demands

Providing support for a better life for family and community. The personal demands that the care workers shared varied from monetary pressure to emotional care. A common motivation among the participants is the higher salary they receive working abroad than if they were to work in the Philippines. Remittances are often sent by the care workers to their family members on a regular basis to assist with numerous obligations such as paying bills, debt, tuition for schools, utilities, investments, etc. Mirna who sends $400-$500 per month to her family in the Philippines shared how being able to financially support them is making her family's life better:

> This is a big opportunity to be here…the only thing that worries me is my family back home, I use that inspiration so I said when I came here I'm going to do a lot of things to make my family's life better, which is what I did…I use this as a stool to make my life better (Mirna, 50 years old).

The concept of interdependence, relying on one another for support, including the responsibility to send money to family members was identified by Nida as a Filipino trait. Nida sent $500 monthly to her family, $3000 during Christmas season, and financial support for each

of her four siblings to build their own homes. She realized later on that this was not enough for them:

> I didn't go on vacation; whatever money I make I send back home to the Philippines. It's my value, when they're happy, I'm happy. I was trying to make my mother happy, I was trying to make her life a little better than what we had. I realized that no matter how much money I sent them, they were not happy. There's always a need.

The pressure that Nida felt from her family led her to resent her family and cease sending remittances after her mother's passing. She stated that her family members have become so dependent on her that she wanted them to realize that she has provided enough financial support that they should learn to make their own money. Since then she has limited her interactions with her family members and is disinterested about returning to the Philippines to visit.

Other care workers provide financial support beyond their family members. Gretchen, 43 years old, sends financial donations that she refers to as tithes to two religious organizations. Care workers deem that they have an obligation not only to their family but also organizations they are involved in because of the opportunity they have to work in the U.S. and earn higher wages.

Demand to save face. Care workers conveyed that they felt pressured to maintain a façade of tailoring positive experiences, avoiding hardships to not worry their relatives who might encourage to come home but also perhaps a way of self-preservation to humanize themselves in their experiences and maintain their dignity. Ligaya, 42 years old, shared how she had to conceal escaping from her employer with Aiza because of abuse and no longer having a job, "I am happy when I talk to them [her children] and that they are able to study even if I'm not there. To my children I don't share with them my situation because they might be affected [negatively]."

Mirna concealed her divorce from her husband initially from her family because she did want them to worry. Even when she did disclose her divorce, she kept the cause of their divorce confidential:

> When I got my first divorce…I did not talk to them about what happened because I did not want them…to worry so I kept it to myself. And then when I did tell them eventually because you know why we're separated…I did not disclose that…maybe the reason behind it I did not want them to worry (Mirna, 50 years old).

Job Resources

Job contracts provides protection and benefits to care workers but lack government oversight. Despite the informality of care work, care workers reported that job contracts provided them worker's protection and resources. Job contracts, while not a requirement for care workers in the informal sector unless they are being hired through an agency or obtaining a visa as a care worker to work in the U.S. for their employer, are often done informally through written or verbal agreements. Aurora, 61 years old, who gets paid $2,000 a month is provided free lodging and food by her employers and they offered to pay for her flight to visit the Philippines every year for three weeks if she wanted to. In addition, she negotiated that her employers pay into her Social Security benefits for her retirement.

Among the workers who were granted a U.S. visa through their employers, the workers discussed that they were informed by the U.S. embassy that they would be granted similar benefits to workers in the U.S. which included a 40-hour work week, lodging, day off, sick pay, and health insurance. However, the lack of government oversight after care workers begin working in the U.S. allow for abuse to occur. Sheila discussed that while her employers met most of the stipulations indicated on her contract, she works overtime and is not paid time and a half after she exceeds her eight-hour work day:

> The only thing that they did not follow is my work schedule, it's supposed to be eight hours only if you follow the 40 hours per week guidelines. But for me, I overloaded with overtime because I work from 6:30 AM to 7:00 PM so that's about 12 to 13 hours or about 12, it's a lot (Sheila, 43 years old).

Melanie, Ligaya, and Aiza also had similar situations as Sheila, but, in addition to working overtime, their employers directly sent their wages in the currency of their employer's country of origin instead of U.S. dollars which is lower than the average minimum wage in the U.S. to their family in the Philippines. They are denied access to having any source of monetary funds to spend while in the U.S. Although they are provided toiletries by their employer, they are not able to purchase other materials that they want such as personal gifts for their family members or daily necessities that they desire beyond conventional needs. Ligaya argued that she endured this because she wants her children to be able to finish their studies:

> Even when I'm really stressed at work, I think about my children going to school. I think about that I need to work for my children because if I give up what about their education? They won't be able to go to school, it's really hard but I have no other choice (Ligaya, 42 years old).

Differing understanding of their rights and where to access resources. When participants were asked about their rights and where to access resources, overall the participants had varying understanding of their rights as workers. Lydia shared what she knows about her rights:

> It is my right to earn a fair wage. Of course, the right to have a break…I think that's it because as I told you I agreed to be paid under-the-table so you know, I only have basic rights no other benefits because they agreed on the wages that I asked from them (Lydia, 63 years old).

Despite working under-the-table, out of the states in New England, in the state of Massachusetts care workers are protected under the Domestic Workers' Bill of Rights which guarantee them certain rights such as minimum wage, overtime pay, and sick leave. Other workers are unsure about their rights and where to access resources and they hope that someone

will help them if ever something were to happen to them at work. When asked about where to seek resources Geraldine, 45 years old, shared, "I know some people who might be able to help me…I don't think my employers will not forsake me in case things were to happen…they know that I am foreign here so I am their responsibility."

Positive working relationship with employers. The majority of care workers discussed that they have an affable working relationship with their employers that makes their working environment pleasant. Mirna describes her working relationship with her employers and his family: "They're not strict, they're flexible, they know how to get along with people. They don't aggravate the care workers that take care of their mother. They have trust in us [care workers] and they trust that we will do our best to take care of their mother."

Other care workers have been considered as family by their employers. Aurora has been working for the same family for over 20 years. She was initially hired to take care of the children, but the children are now working professionals. Aurora out of guilt tried to work elsewhere but her employers asked her to stay for companionship even though she does not have many job responsibilities left:

> The children already graduated from college so I told them I'm going to leave because what am I going to do here? The children are no longer here. They did not like my decision but I felt guilty to still receive wages when I'm not doing anything. My employers told me, "you are family" (Aurora, 61 years old).

Aurora performs general household chores in her employer's home every day such as cleaning and cooking which she completes within a couple of hours. She spends the rest of the day spending time with her employers, lounging, or going to the mall, one of her favorite pastimes.

Personal Resources

Family members and friends as sources of emotional support. Care workers receive and provide emotional support through their family members and friends, whether in-person or

over the phone through social media and other technology-based applications. Many of the participants shared that they use Facebook messenger and would often talk to their family multiple times a day or several times during the week. Some of the participants even developed rituals with their family members. Gretchen, 43 years old, acknowledged that religion is an important aspect of their family, "I call my children everyday, we pray together and talk…because the Lord is important in our lives."

The participants recognized that they approach different people in their networks for various types of support. However, some of the participants also discussed that they do not have anyone they can approach for emotional or financial support:

> Emotionally I have no one, I have to be tough. I have to be tough because I have no one in here to like "Oh we have no money to pay the mortgage this time?" No, it's just me talking to myself you know? No one will help me. Of course, when I have pain in my leg I have to yell downstairs, "I can't walk! Pick me up and drop me off" you know? That's it. Other than that, I have no one I can rely on (Lydia, 63 years old).

Community organizations and spaces provide additional resources. Care workers who are dealing with issues related to accessibility to resources are able to find support through community organizations. Ligaya and Aiza as both human trafficking survivors found support from a local organization that provides them financial support to pay their rent and daily living expenses for food while they await the U.S. government to process their change of status:

> Mrs. Chin, she's the head of this organization. Everytime we come here, she would always approach us to check up on us. We have no choice but to humble ourselves and ask for help because if we do not do that, we are going to go hungry (Ligaya, 42 years old).

Ligaya and Aiza also shared that other church organizations also provide them support by donating food and spiritual support through attending Bible studies.

Aurora, 61 years old, found community through her local church that she said is over 80% Filipina/o. She discussed that there's a gathering of church goers after service every Sunday and they do a lot of activities together that makes it feel like she's part of a family, "In the summer on fourth of July, we would go to the park so the children can enjoy. We are really a family."

Care workers reconnect with their Filipina/o culture to deal with being homesick. The lack of prominent Filipina/o institutions and ethnic enclaves in the New England area and the nature of care work working in isolation can be associated with being homesick and loneliness among care workers. The care workers shared that re-connecting with their Filipina/o culture, specifically through food helps ease the feelings of lonesomeness. Sheila discussed going to her friend's house who is also Filipina to cook Filipino food, "When I want to eat adobo I would go to my friend's house and we would cook it there to satisfy my cravings, sometimes we would go to the Filipino store"

Ligaya watches Filipino shows through her cellphone on platforms like Youtube, "Oh I am not able to sleep if I don't watch my shows [laughs]. I watch Probinsyano and the General's Daughter…I have nothing else to do so I just entertain myself."

Some of the care workers on the other hand avoid watching Filipino shows because it makes them miss home and their family even more:

> What I am trying to avoid is to feel homesick…I love my culture, I love our culture but I am avoiding [Filipino shows] because I don't want to feel sad. I don't like it when my emotions are triggered, I already miss home knowing that I really really miss home [laugh], so why else would I trigger that? I don't want to (Gretchen, 43 years old).

Advocating for themselves and others. After experiencing various instances of discrimination and abuse at work, some participants took it upon themselves to be their own

advocate for themselves and their fellow Filipina/o coworkers. Lydia recalled when she was working in an assisted care facility she became known as the "lawyer" among Filipina/o low-wage care workers, "Every time they fired people, I am their lawyer especially [among] Filipinos. I go with them to Social Security…to support them…to get their unemployment." Lydia not only helped her fellow co-workers earn benefits and fair wages at work but also got involved with a local non-profit organization advocating for low-wage care workers in New England. She stated that it was important for her to help others because she realized that "…there are a lot of people who are looking for help but no one's helping or offering to help them so I put myself out there, if you want me to help you, I'm here." While organizing low-wage workers, Lydia's house also became a refuge for care workers and their family members who experienced domestic violence. Lydia deems that she raised many children of Filipina/o care workers as her own while they resided in her home for years while trying to re-build their lives.

Another form of organizing that some of the care workers engaged in is becoming involved with their profession's union. Nida got involved with the union for childcare providers in her region because, "I don't want to be oppressed, oppression really bugs me… And poor people, just because they're poor doesn't mean they don't work hard, they're getting duped with pay." Nida believes that being involved in the union gave her the opportunity to provide her follow childcare providers with resources about their rights to ensure that people don't take advantage of them.

Three of the participants who are human trafficking survivors used their own agency to seek help from people. Melanie built a relationship with a nanny from a park that she often goes to with the children she takes care of and slowly began to disclose her working conditions. The nanny connected her to a local non-profit organization that helped her plan her escape from her

employer. Aiza befriended someone through social media that they requested to contact 911 on her behalf which led local authorities to remove her and Ligaya from their employer's home:

> I have a friend that I met online…he said "You should report your employers to the police, because what they're doing is abusive, they keep asking you to work but they're not paying you." At that time our employers were no longer paying us…during that time I was so scared to call so he called for us, that's how we were rescued (Aiza, 28 years old).

In the face of adversity, Filipina care workers in the New England region became advocates for themselves and others. They used their network to build relationships and provide resources to others. Moreover, the respondents are not only motivated to help their family members but also their fellow care workers to secure rights and benefits for everyone.

Discussion

This study examined the experiences of Filipina care workers in New England and the facilitation and barriers of demands and resources available to them. We found that the informality of the job has influenced varying demands and resources available to care workers. The demands experienced by care workers are associated to the racialization of the intersections of their gender and identity that employers expect and Filipina care workers embody. Moreover, care workers carry the financial and emotional burden of the stressors of their job and personal lives not only to protect their family but economically support the Philippines. While resources exist, the lack of widespread access to information and oversight of the government placed care workers at risk for abuse and harassment. Nevertheless, the personal agency of care workers allowed them to advocate for themselves and their fellow care workers to access to rights and better working conditions. This study also expands the literature on the JD-R model. Most of the literature on the JD-R model have been used in formal sectors (Kattenbach et al., 2010; Vinod Nair et al., 2020) but have never been employed to understand how job demands and job

resources are reified in the informal sectors. The study also considers personal demands and resources that are not included in the JD-R model. The intersections of care work and being an immigrant and a womxn of color in the U.S. presents its own challenges and advantages that care workers navigate for their survival and their family's success.

This article posits two questions. First, what are the job and personal demands experienced by Filipina care workers? The job demands shared by care workers in the study are similar to extant literature on care workers (Burnham & Theodore, 2012; Hall et al., 2019; Theodore et al., 2018). Performing multiple tasks and the distortion of the working and private space for live-in care workers as shared by Ligaya, Aiza, and Melanie are quite common among care workers. However, care workers like Geraldine are provided clear boundaries of their job responsibilities and allotted time that they are expected to work. This shows that the exploitation of care workers exists within a continuum of employers who acknowledge the rights of their care worker employees while others take advantage of the ambiguity of care work. An important aspect of the job demands that arose in the data is the enduring racialization of the Filipina as care workers and the labor of care being associated with Filipinas (Guevarra, 2010; Rodriguez, 2008). Not only are employers of care workers internalizing this trope but Filipinas themselves also embody this racialization. Perhaps Filipina care workers may feel a sense of comfort and pride knowing that they are trusted to perform their job successfully or it is also possible that they use this trope to rationalize the mistreatment they are experiencing. However, this also affects the additional pressure that Filipina care workers place on themselves as demonstrated by Eva, that the intersections of being a Filipina and a care worker means sacrificing their own well-being for their employer reflecting many Asian cultures, including Filipina/o culture, that operate in a collectivist ideology.

Within the sphere of personal demands, Filipina care workers undertake the responsibility of financially and emotionally supporting their family members. Consistent with extant literature on Filipina care workers (Rodriguez, 2010), the transmission of material goods in the form of remittances and other goods from care workers to their family in the Philippines is a personal demand and moral responsibility that Filipina care workers undertake to improve the lives of their family. In addition, Filipina care workers also shield their family from discussing experiences about their hardships to protect them from worrying, that may affect their mental health. Here we see how the moral economy (Francisco, 2009) that Filipina care workers actively participate in through financially taking care of their family which in turn also sustains the Philippine economy. Furthermore, we see the extension of the moral economy to emotional labor that shelters family members from dealing with the emotional toll of care work in a foreign country placing the burden on Filipina care workers. Scholars argued that this act of shielding is considered tagasalo personality in Filipina/o psychology which refers to someone who bears the problems and stress of the family, often performed by womxn (Arellano-Carandang, 1987; Clemente, 2011; Udarbe, 2001). This may potentially explain associations of poor mental health and suicide ideation among Filipina care workers (Hall et al., 2019; Varia, 2012).

The second question posited by this study asks what are the job and personal resources accessed by Filipina care workers? What are the barriers and facilitators to these resources? The participants discussed numerous job and personal resources that they have access to. In spite of the informality of care work in the informal sector, participants who did have job contracts, written or verbal, provide job security for workers to ensure that they have solidified schedules, access to day off, sick leave, and for some even lodging and utilities. The literature on domestic workers show that only a small percentage of domestic workers in numerous countries have

formalized job contracts (Chen, 2011; Islam et al., 2014). In the U.S., job contracts among care workers in the informal sector are not required. Some care workers are able to formalize job contracts if they are hired by an agency or enter the U.S. by obtaining a U.S. visa along with their employer. However, as our findings showed among care workers with formal job contracts through the accounts of Melanie, Sheila, Ligaya, and Aiza, the absence of government oversight once care workers are working facilitated abuse and harassment of employers on care workers. Similar to previous studies (Chang, 2016; Hsiung & Nichol, 2010), the reasons for barriers reported by care workers range from fear of retaliation, limited alternatives and networks, and being deported which will make their families who are relying on their income financially struggle. It is also possible that care workers do not have a clear understanding of their rights. The participants discussed a wide range of their understanding of their rights and resources, with some having limited knowledge even though the Domestic Workers' Bill of Rights is implemented in the state of Massachusetts. This suggests that local government sectors and non-profit organizations working with care workers in the region need to widen the dissemination of information concerning the rights and resources of care workers to both employers and care workers.

The personal resources that respondents discussed in the study illuminate a sense of personal agency. Lydia and Nida who have been involved with organizing is aligned with numerous instances of low-wage workers who organized to secure worker's rights and benefits. Filipina care workers in various countries have a hxstory of organizing advocating for their rights (Constable, 2009). Lydia and Nida also exemplify the Filipina/o cultural value of kapwa or being one with others (David et al., 2017) that encourages cooperation and camaraderie for people's welfare. Previous studies on Filipina care worker organizing depicted Filipina care workers

operating as independent grassroots organizations working in partnership with other race or ethnic based care worker organizations like in Hong Kong (Constable, 2009) and New York (Francisco, 2009) where a critical mass of these ethnic groups exist to advocate for similar rights. This study demonstrates how the smaller and dispersed population of Filipina care workers in the region engage care workers to organize in worker-focused organizations rather than race or ethnic based organizing to campaign for similar rights showing that labor inequities exist around the world for care workers but it is also the principle of access to their rights that workers can unite on, permeating across ethnic lines. The need to organize among care workers in the informal sector exhibit the care workers in the informal sector are overlooked by the government and policies and resources must be implemented to protect their rights and improve their working condition and well-being which in turn can improve the quality of care and service they are providing to care recipients.

Respondents perceive their family members as a source of personal resource for inspiration to work. Even though some are far away from their family, respondents were motivated to take advantage of the opportunity to work in the U.S. The impetus among care workers to give back to family is an important cultural value among Filipina/os, utang na loob or indebtedness to family (David et al., 2017). While remittances and other material support are perceived as a form of utang na loob for Filipina care workers, Francisco-Menchavez (2018a) argues that the children of Filipina care workers performing well in school and graduating are also forms of reciprocation of utang na loob to the sacrifices of their OFW mothers. Ligaya feeling content that her children are able to study despite experiencing harassment and abuse from her former employers displays the poignant reality of utang na loob.

Limitations

This study has several limitations. The study is conducted in two languages, translating the transcripts from Tagalog to English may have lost some of the meanings and expressions that cannot be conveyed in the English language. Most of the participants recruited are adjacent to or live in a major city, have access to social media, or are involved in community organizations. Their access to information concerning the study may be easier to obtain than care workers who live in more isolated or rural areas of New England. The study focused on care workers but did not interview their employers who can provide different perspectives and information why certain benefits are provided or not provided to their care workers. Participants were also not asked about how long they have been working as a care worker which may illuminate differences in their perceptions of job demands. While the study's purpose is to examine the intersections of care work and Filipinas in New England, it would be imperative to interview care workers of immigrant and other racial or ethnic backgrounds to compare and contrast their experiences in care work in the informal sector.

A strength of the study is that it focuses on Filipina care workers in the New England region expanding the literature in our understanding of experiences of care workers in other geographical sites and discussing the specific pull factors that are bringing Filipina care workers to the area. Existing studies on care workers (Ayalon, 2009; Francisco-Menchavez, 2018a) discussed the direct two-way transaction between the host and receiving countries but as illuminated by some of the experiences of the participants in this study, the initial host countries specifically the Middle East, served as a broker or a mediator for Filipina care workers to work in the U.S. temporarily where they experienced similar expectations and exploitation by their employers in their initial host countries. The use of the JD-R model to examine the experiences of care workers in the informal sector showed its relevance and the need to include personal

demands and resources as additional constructs to be considered because of the intimacy and permeability of care work that blurs the line between work and personal space. Finally, the study underscores not only the limited policies protecting workers but it illustrates the policies' inaccessibility and government accountability in ensuring the safety and well-being of care workers.

Conclusion

The purpose of the study aims to assess the experiences of Filipina care workers in New England and how they access job and personal resources to potentially mitigate the demands of their working environment and personal lives. The findings from the study shows that the demands experienced by care workers are associated with the racialization of their occupation because of their gender and race that are internalized both by their employers and themselves. Moreover, Filipina care workers financially and emotionally support their family but also the Philippine economy which may negatively influence the overall well-being of care workers. Despite the availability of resources additional barriers exists because of inaccessibility to information, fear, and lack of government culpability. However, Filipina care workers learned to advocate for themselves and others through organizing and leveraging the resources they have to find and provide support. The increasing demand of care workers and the New England area as a prominent destination for employers of care workers indicate that need for the local, state, and federal government as well as the sending nation to ensure that both employers and employees are cognizant of their rights and resources. Social work can address this issue by working alongside agencies, organizations, employers, and workers to provide resources available in numerous Filipino languages and advocate for improved implementation of the Domestic

Worker's Bill of Rights in Massachusetts and its passing in other states in New England and the federal version.

Chapter VI. Conclusion

The question posited in this dissertation is, "What are the buffering effects of job and personal resources on the association of job and personal demands on the health and well-being of care workers?" The results from this study showed varied findings. In the formal setting, job resources like people-oriented culture, though it did not moderate the relationship between discrimination and short sleep duration among care workers, it partially attenuated its associations; this means that accounting for people-oriented culture in the model lowered the odds of short sleep in relation to experiences of discrimination but not significantly. Workplace flexibility, on the other hand, moderated the relationship of job and personal demands and burnout among some, but not all, workers. In the informal sector, certain factors such as job contracts, amicable relationship with employers, and social network support have been helpful for care workers in mitigating the demands of their job and personal spheres. The present dissertation shows that alleviating the job and personal demands of care workers are complex; current existing organizational policies and practices, whether in the formal or informal sectors, may not necessarily be effective for everyone. This present dissertation has two general findings, 1) policies and practices have some influence in attenuating poor health outcomes, however, 2) not all care workers benefit from these policies and practices.

Finding #1: Organizational policies and practices attenuate poor health outcomes.

Organizational policies and practices have some impact on the negative health outcomes of care workers. In paper 2, workplace flexibility moderated the association of burnout among married care workers without children. Previous studies have suggested that childless married healthcare workers may experience burnout because of work-family backlash where childless married workers are expected to be flexible compared to their co-workers who have children

(Young, 1999). In paper 1, people-oriented culture did not moderate the negative association of discrimination and short sleep duration among care workers. However, people-oriented culture slightly attenuated the association of discrimination and short sleep duration, meaning that adjusting for workplace flexibility lowered odds of short sleep in relation to experiences of discrimination. Qualitative interviews provided an in-depth understanding of why people-oriented culture did not buffer the relationship between discrimination and short sleep duration in the way that we hypothesized. Interviews from unit nurse directors indicated that resources in their workplace do not provide services and programs that specifically addressed systems of oppression and inclusivity in the workplace. But some of the hospital units created their own resources and programs that addressed other needs of the workers which may have contributed to the workplace culture which may have some influence in attenuating the odds of short sleep and experiences of discrimination.

This finding indicates that while shifting the entire culture and making structural changes in the workplace may take time and may be difficult to accomplish easily, unit supervisors can make incremental changes in their units. For example, since unit supervisors facilitate the scheduling of nurses and PCAs in their units, they can provide flexibility among workers who may need more consistent schedules, last minute requests to leave early for work or take a sick leave because of personal emergencies, and other aspects that can be controlled within the unit level. Moreover, to address discrimination in the workplace, it must be identified explicitly (Bassett, 2017) and trainings and discussions addressing various forms of discrimination (e.g. racism, sexism, homophobia, transphobia, etc.) must be on-going and consistent to make impactful changes (C. K. Lai et al., 2016) that can be integrated in the practices and meetings

within the units. These practices should be disseminated across other units which can hopefully engender structural changes within hospitals at-large.

Finding #2: Inequities in accessibility to organizational policies and practices.

Despite the existence of policies and practices in the formal and informal sectors, not all workers benefit from these resources. In paper 2, further examination of the role of workplace flexibility indicated that care workers with perceived low workplace flexibility and were active (high demand, high control) and high strained (high demand, low control) had higher odds of burnout, specifically high strained workers. The condition of the demands in the healthcare industry among workers, 24/7 care, and changing shifts compounded with variations in responsibilities and latitude and personal responsibilities (Bullock & Waugh, 2004), show that while workplace flexibility is technically practiced by organizations, not all workers are granted the entirety of its benefits because of variations in demands, latitude, and job prestige that grants some workers more flexibility than others (Kossek & Lautsch, 2017). More importantly, in considering the intersection of identities, while womxn in general experience discrimination by being denied access to policies and practices like flexibility and instead are more likely to be fired once their employers find out they are pregnant, Black womxn, whether low-income or middle class, are more likely to experience these forms of discrimination at higher rates than their white womxn counterparts (Ortiz & Roscigno, 2009). In paper 3, among informal care workers, while job resources such as job contracts and limited policies exists, the lack of government oversight and access to information about worker's rights for both employers and care workers allow for abuse, violence, and harassment to transpire. For workers additional barriers to reporting abuse also exist, consistent with previous literature (Chang, 2016; Hsiung & Nichol, 2010), the demand to earn and send money to support their family outweighs experiences

of abuse in the workplace. This suggests that even if protection for workers are available, other systemic obstacles like their families living in poverty in their home countries are deterring care workers experiencing abuse in their workplace from reporting. Care workers sacrifice their own health and well-being by enduring unjust working conditions for their family's survival.

Social Work Implications

Education. The study interrogates the role of social workers in relation to occupational health and well-being. Scholars have argued for the role of social workers in occupational health through the cultivation and implementation of occupational social work. Schools of social work should consider establishing a concentration in occupational social work. This concentration can be achieved through five tenets: advocacy, mediation, brokerage, problem-solving strategies, and education (Bates & Thompson, 2007). Portions of these tenets are already existent in social work courses that prepare students in policy analysis, administration, and clinical practices. Departments can integrate literature about occupational policies, management, and health to cater towards the practice of occupational social work. Social workers can then be equipped to address policies and practices that can potentially lower the likelihood of burnout in the workplace. Another aspect of social work education that needs to be addressed based on the findings from this study is that social work must adopt an educational curriculum that addresses racism and other forms of oppression. Research on social work literature have shown that social work curriculum is racist (Corley & Young, 2018; McMahon & Allen-Meares, 1992). Social work education operates within a white, male, and heterosexual lens that promotes white saviorism. Occupational social workers and social workers at-large should be taught a social work curriculum that integrates critical analysis of their own identities, systems of oppression, and social work practices that embodies anti-racism.

Practice. Addressing the welfare of care workers is within the scope of responsibilities and duties of the social work profession. The ethical principles in the social work code of ethics specifically state that "social workers' primary goal is to help people in need and to address social problems" and "social workers challenge social injustice" (National Association of Social Workers, n.d.). Social workers may be well positioned to advocate for the health and safety of workers in the workplace because social workers are broadly trained to provide clinical services but also how to navigate the various levels of policies and mechanisms of the workplace to enact structural changes and interventions (Bates & Thompson, 2007). For instance, occupational social workers can facilitate the establishment of programs and services improving employee well-being or in administrative roles that evaluate and modify policies and experiences of workers that are affecting their health and well-being (Sabbath, 2019).

Policy. In the policy level, social workers can advocate for family-friendly policies. For instance, lobbying for more states to pass iterations of the Paid Family Leave (PFL) to address personal demands that workers are experiencing without fear of losing their job and with guaranteed partial pay during their leave of absence (Baum II & Ruhm, 2016). Policies like PFL also needs to be extended to care workers in the informal sector. Within the informal sector, social workers should advocate for the ratification of city, state, and federal versions of the Domestic Worker's Bill of Rights, whichever version is passed first. Social workers can also advocate for the United States Citizenship and Immigration Services (USCIS) that once visas for care workers are granted, that their employers adhere to the job contract agreed upon by employers and their care workers as a stipulation in being granted the visa to work in the U.S.

Research. Future studies should consider examining other policies and practices in the workplace as well as local, state, and federal policies that are influencing the demands and

stressors experienced by care workers in their job and personal domains and how it affects their health and well-being. In light of the recent COVID-19 pandemic, the risks experienced by care workers are intensified which may suggest that care workers are even more vulnerable. It is imperative to conduct research evaluating and identifying policies and practices that are effective or need modification to protect the overall health of care workers while providing care to their patients.

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Appendices

Appendix A

Table 5. Multivariate regression modeling of relationship of workplace discrimination and hours of sleep. [*B*=Unstandardized Coefficient; SE *B* = Standard Error; Beta = Standardized Coefficient.]

	Model 1 *B*(SE *B*) Beta	Model 2 *B*(SE *B*) Beta	Model 3 *B*(SE *B*) Beta	Model 4 *B*(SE *B*) Beta	Model 5 *B*(SE *B*) Beta	Model 6 *B*(SE *B*) Beta	Model 7 *B*(SE *B*) Beta	Model 8 *B*(SE *B*) Beta	Model 9 *B*(SE *B*) Beta	Model 10 *B*(SE *B*) Beta
Discrimination	-.15(.05)-.10**	-.10(.05)-.07*	-.08(.05)-.06	-.07(.06)-.05	-.12(.05)-.08*	-.09(.06)-.06	-.07(.06)-.05	-.13(.05)-.09**	-.12(.05)-.08*	-.10(.05)-.07
People Oriented Culture		.12(.05)-.08*	.13(.06).06*	.13(.06).09*						
Supervisor Support					.02(.01).06	.03(.01).07	.03(.01).08*			
Co-Worker Support								.03(.03).04	.02(.03).03	.02(.03).03
Age (ref <30)										
30-39			-.09(.10)-.04	-.14(.10)-.06		-.11(.10)-.05	-.16(.10)-.07		-.12(.10)-.05	-.17(.10)-.07
40-49			.06(.11).02	-.04(.10)-.01		.05(.10).02	-.06(.10)-.02		.04(.10).01	-.08(.10)(.02)
50+			-.05(.10)-.02	-.10(.10)-.04		-.08(.10)-.03	-.13(.10)-.06		-.08(.10)-.03	-.13(.10)-.05
Gender (ref Men)										
Womxn			-.02(.16)-.01	-.08(.16)-.02		-.03(.16)-.01	-.09(.15)-.02		-.03(.16)-.01	-.09(.15)-.02
Race (ref White)										
Black			-.11(.21)-.03	-.09(.21)-.02		-.14(.21)-.04	-.13(.21)-.03		-.11(.21)-.03	-.13(.21)-.03

Latinx	-.20(.17)-.04	-.15(.17)-.03	-.22(.17)-.04	-.17(.17)-.03	-.22(.17)-.04	-.17(.17)-.03
Other	-.35(.21)-.07	-.33(.21)-.07	-.37(.21)-.07	-.36(.20)-.07	-.36(.21)-.07	-.36(.20)-.07
Immigrant Status (ref U.S. Born)						
Non-U.S. Born	.06(.11).02	.09(.11).03	.07(.11).02	.10(.11).04	.07(.11).03	.10(.11).04
Job Title (ref Nurse)						
PCA	-.25(.15)-.07	-.26(.15)-.07	-.27(.16)-.07	-.27(.16)-.08	-.23(.15)-.06	-.27(.16)-.08
Other	.21(.14).04	.30(.13).06*	.17(.14).03	.26(.13).05*	.21(.14).04	.26(.13).05*
Hours Worked Per Week		-.02(.35)-.13***		-.02(.004)-.14***		-.02(.004)-.14***

*p < .05, **p < .01, ***p < .001

Appendix B

Table 6. Logistic regression modeling of relationship of workplace discrimination and hours of sleep with supervisor support and co-worker support. [OR=odds ratio; 95% CI= 95% confidence interval.]

	Model 1 OR(95% CI)	Model 2 OR(95% CI)	Model 3 OR(95% CI)	Model 4 OR(95% CI)	Model 5 OR(95% CI)	Model 6 OR(95% CI)
Discrimination	1.44(1.16,1.79)**	1.36(1.08,1.71)**	1.32(1.05,1.67)*	1.43(1.16,1.76)***	1.38(1.11,1.72)**	1.36(1.08,
Supervisor Support	.98(.91, 1.05)	.96(.90,.103)	.96(.89,1.03)			
Co-worker Support				.92(.80, 1.06)	.92(.79,1.06)	.91(.78,1.06)
Age (ref <30)						
30-39		1.05(.63,1.77)	1.16(.69,1.95)		1.07(.64,1.79)	1.18(.70,1.98)
40-49		.79(.49,1.29)	.97(.59,1.61)		.80(.49,1.31)	.98(.59,1.63)
50+		1.06(.66,1.72)	1.16(.72,1.88)		1.04(.63,1.69)	1.13(.69,1.84)
Gender (ref Men)						
Womxn		1.04(.59,1.85)	1.18(.66,2.11)		1.06(.60,1.87)	1.20(.68,2.12)
Race (ref White)						
Black		2.24(1.03,4.87)*	2.16(.98,4.78)		2.16(.98,4.76)	2.08(.93,4.65)
Latinx		2.09(.88,4.93)	1.86(.76,4.55)		2.08(.88,4.93)	1.85(.75,4.55)
Other		2.57(1.07,6.14)*	2.52(1.06,5.98)*		2.57(1.08,6.13)*	2.52(1.06,5.97)*
Immigrant Status (ref U.S. Born)						
Non-U.S. Born		1.12(.61,2.06)	1.21(.64,2.28)		1.15(.62,2.11)	1.24(.65,2.35)
Job Title (ref Nurse)						
PCA		1.16(.65,2.06)	1.17(.64,2.13)		1.28(.71,2.32)	1.32(.71,2.43)
Other		.70(.29,1.67)	.60(.25,1.42)		.74(.31,1.77)	.64(.27,1.54)
Hours Worked Per Week			1.04(1.01,1.06)**			1.04(1.01,1.06)**

*p < .05, **p < .01, ***p < .001

Appendix C

Table 7. Logistic regression modeling of relationship of workplace-related discrimination and hours of sleep. [OR=odds ratio; 95% CI= 95% confidence interval.]

	Model 1 OR(95% CI)	Model 2 OR(95% CI)	Model 3 OR(95% CI)	Model 4 OR(95% CI)
Discrimination 2	1.44(1.21,1.71)***	1.30(1.07,1.58)**	1.25(1.02,1.52)*	1.23(1.00,1.51)
People Oriented Culture		.69(.54,.89)**	.67(.51,.87)**	.66(.51,.86)**
Age (ref <30)				
30-39			.96(.57,1.61)	1.06(.63,1.77)
40-49			.73(.45,1.20)	.89(.54,1.49)
50+			.95(.58,1.55)	1.03(.63,1.69)
Gender (ref Men)				
Womxn			1.03(.57,1.85)	1.15(.64,2.08)
Race (ref White)				
Black			2.19(1.00,4.79)*	2.07(.93,4.61)
Latinx			1.97(.81,4.84)	1.76(.70,4.43)
Other			2.50(1.04,5.98)*	2.42(1.01,5.79)*
Immigrant Status (ref U.S. Born)				
Non-U.S. Born			.94(.51,1.75)	.88(.46,1.69)
Job Title (ref Nurse)				
PCA			.83(.46,1.50)	.82(.44,1.51)
Other			.56(.26,1.23)	.47(.23,.98)*
Hours Worked Per Week				1.04(1.01,1.06)**

*p < .05, **p < .01, ***p < .001

Appendix D

Table 8. Logistic regression modeling of relationship of non-workplace related discrimination and hours of sleep. [OR=odds ratio; 95% CI= 95% confidence interval.]

	Model 1 OR(95% CI)	Model 2 OR(95% CI)	Model 3 OR(95% CI)	Model 4 OR(95% CI)
Discrimination 3	1.26(1.01,1.56)*	1.12(.88,1.42)	1.08(.84,1.39)	1.07(.83,1.38)
People Oriented Culture		.63(.50,.80)***	.61(.48,.78)***	.61(.48,.79)***
Age (ref <30)				
30-39			.93(.55,1.56)	1.02(.61,1.72)
40-49			.73(.45,1.19)	.89(.54,1.48)
50+			.93(.57,1.52)	1.02(.62,1.67)
Gender (ref Men)				
Womxn			.99(.55,1.77)	1.12(.61,2.02)
Race (ref White)				
Black			2.34(1.09,4.99)*	2.19(1.00,4.82)
Latinx			2.09(1.09,4.99)*	1.85(.75,4.58)
Other			2.56(1.07,6.14)*	2.48(1.04,5.92)*
Immigrant Status (ref U.S. Born)				
Non-U.S. Born			.92(.50,1.70)	.86(.45,1.64)
Job Title (ref Nurse)				
PCA			.90(.50,1.62)	.89(.48,1.63)
Other			.54(.25,1.19)	.46(.22,.95)*
Hours Worked Per Week				1.04(1.01,1.06)**

*p < .05, **p < .01, ***p < .001

Appendix E

Table 9. Interaction terms between workplace-related discrimination and people-oriented culture. [OR=odds ratio; 95% CI= 95% confidence interval.]

	OR(95% CI)
Discrimination 2	1.28(1.02,1.61)*
People Oriented Culture	.70(.54,.90)**
Discrimination x People Oriented Culture	.97(.81,1.16)

*p < .05, **p < .01, ***p < .001

Appendix F

Table 10. Interaction terms between non-workplace related discrimination and people-oriented culture. [OR=odds ratio; 95% CI= 95% confidence interval.]

	OR(95% CI)
Discrimination 3	1.13(.87,1.47)
People Oriented Culture	.63(.50,.80)***
Discrimination x People Oriented Culture	1.03(.78,1.35)

*p < .05, **p < .01, ***p < .001

Appendix G

Table 5. Demographic characteristics of married no child sample. (n=323) [SD=standard deviation].

	Observations (%) or Mean ± SD
Burnout	
No	223 (69.04%)
Yes	100 (30.96%)
Job Strain	
Low Strain	69 (21.36%)
Passive	67 (20.74%)
Active	87 (26.93%)
High Strain	100 (30.96%)
Workplace Flexibility (1-5; higher=better)	1.54 ± .24
Age	
<30	114 (35.29%)
30-39	75 (23.22%)
40-49	22 (6.81%)
50+	112 (34.67%)
Gender	
Men	29 (8.98%)
Womxn	294 (91.02%)
Race	
White	283 (87.62%)
Black	14 (4.33%)
Latinx	14 (4.33%)
Other	12 (3.72%)
Immigrant Status	
U.S. Born	287 (88.85%)
Non-U.S. Born	36 (11.15%)
Job Title	
Nurse	292 (90.40%)
PCA	18 (5.57%)
Other	13 (4.02%)

Appendix H

Table 6. Observations of job strain by personal demands.

Family Status	Low Strain Observations (%)	Passive Observations (%)	Active Observations (%)	High Strain Observations (%)
Single no child	43 (24.02)	65 (27.78)	60 (28.57)	64 (25.50)
Single with child	7 (3.91)	17 (7.26)	7 (3.33)	14 (5.58)
Married no child	69 (38.55)	67 (28.63)	87 (41.43)	100 (39.84)
Married with child	60 (33.52)	85 (36.32)	56 (26.67)	73 (29.08)

Appendix I

Table 7. Mean average score of workplace flexibility by personal demands.

Family Status	Workplace Flexibility Mean ± SD
Single no child	1.54 ± .23
Single with child	1.58 ± .20
Married no child	1.54 ± .24
Married with child	1.54 ± .25

Appendix J

Table 8. Observations of personal demands by low and high workplace flexibility.

	Low Workplace Flexibility Observations (%) n=439	High Workplace Flexibility Observations (%) n=435
Family Status		
Single no child	117 (50.43)	115 (49.57)
Single with child	16 (35.56)	29 (64.44)
Married no child	169 (52.32)	154 (47.68)
Married with child	137 (50.00)	137(50.00)

Appendix K

Question Guide for Asian American Home Care Worker's Study

Disclaimer: Before we begin the study, during the interview, please do not share your documentation status in any way.

Demographic Questions:

1. What is your age?
2. What is your ethnicity?
3. What is your highest level of education?
4. How long have you been living in the U.S.?
5. Are you married?
6. Do you have any children? If yes, how many?
7. How many people you live with?
8. Do you have health insurance?

Work Experience

9. How many jobs do you currently have?
10. What is/are your current job(s)?
11. How did you hear about the job?
12. How much do you get paid per month? And in what form?
13. Do you send money back to your family? If yes, how much, how often, and through what means?
14. How many hours do you work per day? Per week? Per month?
15. How many people do you take care of?
16. What are your job duties?
17. Did you have a contract with your employer before beginning work? If yes, was it written or verbal? What did the contract state? Did you have the opportunity to negotiate?
18. What is your relationship like with your employer?
19. Describe your experience working?
20. Have you ever experienced discrimination at work? Explain. How did it make you feel?
21. Do you get to take breaks at work? If not, why? If yes, what do you do during your break?
22. Have you been injured at work? If yes, what did you do?
23. How do you usually feel at the end of a work day? How do you cope?
24. Do you get sick days? If yes, how many?
25. Do you get vacation days? If yes, how many?
26. Do you know your rights as a worker? If yes, what are the rights you know of? How did you learn about these rights? If not, do you know where to go to learn about your rights?

Support and Coping

27. What emotions do you feel living in the U.S.?

28. Have you ever experienced discrimination outside of work? Explain. How did it make you feel?
29. Who do you turn to for support and what kind of support do you need?
30. Do you keep in touch with family and friends back in your home country? How often? What medium do you use to contact them (Whatsapp, Skype, Google Hangout, other)? What are common topics that you discuss about? Are there topics that you avoid discussing with them? Why?
31. Is it easy or difficult to access your culture in the U.S.? (food, people, spaces, language, movies/tv shows)? What type do you usually try to access? How does it make you feel to have access or no access to these mediums?
32. Do you prefer accessing American culture? (language, food, spaces, movies/tv shows, etc.) Explain.
33. Do you want to settle in the U.S. or go back home? Explain.